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**MAG Doctor of the Day for
the State Legislature.**

See page 15

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Cover

Our cover depicts a member of the Medical Association of Georgia leaving the State Capitol after a day of volunteering his services to the State Legislature. The Doctor of the Day program, begun in 1969, has been an excellent public relations gesture on the part of MAG. Drs. Carl Drury of St. Marys and Alex B. Russell of Winder, as members of the House of Representatives, also serve in the best interests of Georgia physicians, as well as their own constituents. Layout by Marie Seaman.

*A timely review of basic cardiac
auscultatory findings.*

General Highlights of Cardiac Auscultation

JOSEPH K. PERLOFF, M.D., *Washington, D.C.*

THE PRACTICAL USE of cardiac auscultation requires an understanding of certain elementary principles. First, auscultatory events must be *heard* before they can be interpreted; accordingly, the technicalities and techniques of auscultation are paramount. Second, recognition of the various heart sounds, especially the first and second sounds, defines systole and diastole and establishes the timing of the different phases of the cardiac cycle. Third, the timing of murmurs can readily be accomplished once the phases of the cardiac cycle are defined. The following remarks will touch on each of these three principles.

Technicalities and Techniques

The chain of success in this area consists of a number of links. The *instrument* of auscultation is the stethoscope that was introduced by Laennec in 1819. The ideal stethoscope is yet to be devised but good instruments are available and certain guidelines are useful in their selection. Both a bell and a diaphragm are necessary, the former for the low frequency ranges and the latter for the high. Connecting tubing should be relatively firm and single; double tubes are acoustically less efficient and cause extraneous noise when they touch or rub together. The overall length of the entire stethoscope should be about 22 inches. The binaural ear pieces should be relatively large so that they occlude the external auditory canals and do not uncomfortably enter them. Finally, all connections must be airtight in order to avoid loss of sound by leakage.

The next link in the chain is the sensing device, i.e. the human ear which can be trained to sense the broad range of frequencies emanating from the heart and blood vessels. It is encouraging to know that the

ear is more efficient than the phonocardiogram in recognizing high frequencies such as the soft murmur of aortic incompetence. The ears are all important since even the best stethoscopes do *not* amplify sound but merely transmit it to the ears with relatively little loss. Perhaps the most important link in the chain is the interval between the stethoscopic ear pieces, namely, the human brain. The brain interprets what is heard, and in order to do so effectively it must be programmed by years of experience. Once these technical links—the instrument, the sensing device, the interpreter and the programming—are forged, we can turn attention to the auscultatory technique itself.

Auscultation should be conducted in a quiet examining room that is free of ambient noise and that has a temperature so regulated as to avoid shivering. The patient must be relaxed and comfortable and the examiner unhurried. Various postures should be employed such as supine, prone, left lateral decubitus, sitting, leaning forward, standing, or squatting. Respiratory patterns should also be appropriately selected including quiet or arrested breathing for routine auscultation, full held expiration for the soft murmur of aortic incompetence, or normal or exaggerated respiratory excursions for the behaviour of the second heart sound or for certain right-sided events. Physical and pharmacologic interventions are useful and include coughing, effort, squatting, isometric tension (squeezing the clinched fists), and certain vasoactive drugs, especially amyl nitrite and pressor agents. When the bell of the stethoscope is applied with varying degrees of pressure, a relatively broad range of frequencies can be elicited. When the bell is touched lightly to the skin, low frequencies are heard (soft third heart sound); when high frequencies are paramount, firm pressure with the diaphragm is required. Palpation should precede aus-

AUSCULTATION / Perloff

cultation so that the stethoscope can be placed precisely at the most appropriate precordial sites. Finally, auscultation should not be confined to the precordium but should include the right chest, axillae, back, neck, flanks, abdomen, groins, and at times the eyeballs and skull.

The Heart Sounds

The normal heart sounds define the phases of the cardiac cycle and serve as standards by which abnormal heart sounds can be judged. The first heart sound is best assessed at the apex or lower left sternal edge and is either single or closely split. Splitting is usually confined to the lower sternal edge and is normally not heard at the base. Although analysis of the first heart sound provides helpful information, analysis of the *second* heart sound is far more useful and has been called the key to auscultation of the heart. Proper interpretation of the second sound assumes an awareness of its location, splitting, and intensity. In the second left intercostal space there are two components, aortic and pulmonic, which are synchronous (or nearly so) during expiration and split during inspiration. A judgment regarding the intensity of pulmonary valve closure requires comparison with aortic closure when *both* sounds are heard simultaneously during inspiration. The comparative softness of the pulmonary closure sound is held responsible for its localization in the vicinity of the second left intercostal space, and the relative loudness of aortic closure accounts for its audibility at all areas. It should clearly be stated that A_2 refers to *aortic* valve closure and P_2 to *pulmonary* valve closure. A_2 and P_2 do *not* refer to the second heart sound in the "aortic" vs. the "pulmonary" area; such use implies a complete misunderstanding of the origin of the two components of the second sound. Similarly, P_2 by definition is a single sound caused by pulmonary valve closure, so the expression "split P_2 " is a misnomer that should be abandoned.

The third and fourth heart sounds are best understood in relation to the two diastolic phases of ventricular filling. These sounds originate *within* the recipient ventricle, the third sound during the mid-diastolic filling phase and the fourth sound during the presystolic filling phase. Accordingly, a fourth heart sound implies sinus rhythm. Both sounds are low frequency events that are most readily heard with light touch of the stethoscopic bell.

Abnormal Events

The foregoing heart sounds—first, second, third, and fourth—can either be normal or abnormal. The

following sounds are, for all practical purposes, abnormal events.

Opening snaps characteristically originate in the mitral valve, usually because of stenosis. The snap is relatively high frequency, is heard not only at the apex but also at the sternal edge and base, and is best elicited with the stethoscopic diaphragm or firm pressure with the bell. Since the mitral valve must open before the ventricle can fill, the timing of the opening snap necessarily precedes the timing of the third heart sound.

Ejection sounds are high pitched, clicking early systolic events that originate in either the left heart (aortic valve or dilated ascending aorta) or right heart (pulmonic valve or dilated pulmonary trunk). These sounds tend to be heard at the *base* of the heart and should not be mistaken for split first heart sounds. The aortic ejection sound is well-heard at both the base and apex and with rare exception does not vary with respiration; the pulmonic ejection sound is well-heard in the second left intercostal space and often varies characteristically with respiration, getting selectively softer with inspiration and louder with expiration.

Systolic clicks must be distinguished from ejection sounds. The clicks are similar to ejection sounds in frequency but not in timing or chest wall location. Clicks generally originate in redundant mitral chordae tendineae; they are single or multiple, maximal at the apex, and begin in mid-to-late systole.

Cardiac Murmurs

A cardiovascular murmur is a relatively prolonged series of auditory vibrations characterized according to intensity (loudness), frequency (pitch), configuration (shape), quality, duration, direction of radiation and timing in the cardiac cycle. The timing of murmurs is particularly important since it serves as a basis for classification. Systolic murmurs are classified according to their time of onset and termination as midsystolic, holosystolic, early systolic, or late systolic. A midsystolic murmur begins after the first heart sound and ends before the second sound (aortic stenosis). A holosystolic murmur begins with the first heart sound, occupies all of systole, and ends with the second heart sound (classic mitral incompetence). Early systolic murmurs begin with the first heart sound, diminish in a decrescendo fashion, and end at or before midsystole (very small ventricular septal defect with early systolic shunt). Late systolic murmurs begin in mid-to-late systole and end with the second heart sound (mitral incompetence with late systolic regurgitation). Finally, *extracardiac systolic arterial murmurs* originate in either systemic or pulmonary arteries. The existence of

such murmurs emphasizes the importance of careful auscultation at nonprecordial sites.

Diastolic murmurs are classified according to their time of *onset* as early diastolic, middiastolic, or late diastolic (presystolic). An early diastolic murmur begins with the second heart sound (aortic incompetence). A middiastolic murmur begins at a clear interval after the second heart sound (mitral stenosis with atrial fibrillation). A late diastolic murmur or presystolic murmur begins in the period immediately before the first heart sound (mitral stenosis with sinus rhythm).

The term "continuous" is best applied to murmurs that begin in systole and continue without interruption through the time of the second heart sound into all or part of diastole. Persistence of murmurs throughout the cardiac cycle is therefore not a requirement. Accordingly, a murmur that proceeds

into diastole without stopping at the second heart sound is considered continuous whether or not it finishes before the next first heart sound. Continuous murmurs can be due to aortopulmonary communications (patent ductus), arteriovenous connections (systemic arteriovenous fistulas), or can be purely arterial (arterial constriction), or purely venous (venous hum).

Summary

There are few areas of clinical cardiology that auscultation does not animate. This paper has reviewed three areas relevant to this topic: 1) the technicalities and techniques of auscultation, 2) the heart sounds, and 3) cardiovascular murmurs. Skill in auscultation remains a hallmark of the good clinician and it is understandable why this is so.

Georgetown University School of Medicine

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL NOVEMBER 30, 1970

Peer Review: Adopted a policy manual on peer review with the exception of a statement of criteria for submission of claims to the committees. That section will be considered at the December meeting.

Usual and Customary Contracts: Adopted a resolution recommended by the Committee on Insurance and Economics calling on Georgia's Blue Cross-Blue Shield Plans to seek a more aggressive intrastate sale of their usual, customary or reasonable fee contracts in addition to their other plans.

CHAMPUS: Decided to notify OCHAMPUS that MAG would issue reimbursements from MAG for services rendered by practitioners licensed under the Composite Board of Medical Examiners.

Appointments: Confirmed the nomination of John

Rhodes Haverty, M.D., for appointment to the AMA Council on Health Manpower.

Also received word that Robert Perry, M.D., Brunswick, was elected Chairman of the recently appointed Board of Health Advisory Committee on Clinical Laboratories, Blood Banks and Tissue Banks.

Medicare: Decided to seek an opinion from legal counsel on whether or not Public Law 89-97 provides for the establishment of prevailing fee limitations.

Council: Referred for consideration by the Council questions regarding MAG positions on: 1) Certification of Need in location of hospital facilities, and 2) Podiatry hospital staff privileges.

Next Meeting: 10:00 a.m., Saturday, December 12, Holiday Inn, Valdosta, Georgia.

HIGHLIGHTS OF BOARD OF DIRECTORS, GEORGIA MEDICAL CARE FOUNDATION, INC.

Election of Officers: Elected 1971 officers were:

President and Treasurer: F. W. Dowda, M.D., Atlanta

Vice President: F. G. Eldridge, M.D., Valdosta

Secretary: John Kirk Train, Jr., M.D., Savannah

Executive Director: Edwin F. Smith (MAG, Tentative)

Accounting: Georgia Medical Care Foundation's accounting will be done by the Medical Association of Georgia Headquarters with appropriate cost reimbursement.

Auditing: Ernst and Ernst were designated as the Georgia Medical Care Foundation's auditing firm.

Administrative Charge: A maximum of 5 per cent

of premium was determined as the administrative charge to carriers.

Membership Dues: Nominal annual dues for participating membership will not exceed \$10.00. Future contract provisions may eliminate the need for annual dues.

MAG Liaison: Discussed as a desirable future amendment to the Bylaws was the idea of MAG officers as ex-officio members of the Georgia Medical Care Foundation Board.

Board Meetings: It was determined that the Board will meet in conjunction with the meetings of the MAG Council.

Next Meeting: Sunday, March 21, 1971, Macon Hilton.

The need of physicians for adequately trained and motivated nursing and technical personnel in this field is extreme.

An Analysis of the Teaching of Diabetic Patients

MISS MARY SINGLETON, R.N.,* *Augusta*

WHILE WORKING at University Hospital, I have encountered many patients with the diagnosis of diabetes mellitus. Many of these patients had been admitted to the hospital due to complications arising from improper control of their disease, such as gangrene and diabetic ketoacidosis.

This year alone, a quarter of a million people will hear the frightening news, "You have diabetes."¹ The incidence is rising, partially because of improved case-finding methods and partially because increasing longevity gives people more time to develop diabetes.²

In the United States alone there are approximately two and one-half million known diabetics, while one and one-half million more are unaware that they have diabetes. "The key to the care of these menaced millions is self-care; and self-care is achieved only through skilled education."³

In November, 1965, there were only half a million nurses taking care of *all* patients (not just those with diabetes), and four million patients to be taught or retaught. The question then arises as to how can we hope to meet these colossal needs.⁴

The diagnosis of diabetes mellitus brings with it many complex problems, including serious complications. Therefore, health teaching must play a very important role in the nursing care of patients with

diabetes mellitus. At first many patients find it hard to accept their diagnosis because of false concepts and fears. A sound program of instruction adapted to the individual patient can help him accept his therapeutic regimen.⁵

Irene Beland has given us some objectives to follow in teaching the diabetic patient, as illustrated in the following quotation.

Health programs, as they relate to diabetes mellitus, have two general objectives. The first is to prevent or, if this is not possible, to delay the onset of the disease. The second is to maintain the health and vigor of the individual throughout his life. In the achievement of these objectives the nurse has three general responsibilities. The first is to aid in the detection of persons who are predisposed to or in the early stages of diabetes mellitus. The second is to participate in the education of the patient, his family, and the community in the management of diabetes mellitus. The third is to meet the needs of the sick person for nursing. Frequently the nurse performs all these functions more or less simultaneously. No nurse should accept the responsibility for the care of the patient with diabetes mellitus unless she knows as much as the *well-educated* patient is expected to learn about his disease.⁶

Purpose of the Study

The purpose of this study was to determine if the amount of teaching the diabetic patient receives at University Hospital is adequate to meet his needs. The areas included for study were insulin adminis-

* Presented to the faculty of the University Hospital School of Nursing in partial fulfillment of the requirements of team nursing, May 25, 1970.

¹ Krysan, Germaine S.: How do we teach four million diabetics; *A.J.N.* 65:105, November, 1965.

² Smith, Dorothy W. and Gips, Claudia D.: *Care of the adult patient*; Philadelphia and Toronto, J. B. Lippincott Company, 1966, p. 793.

³ Krysan, *op. cit.*, p. 105.

⁴ *Ibid.*, p. 105.

⁵ Beland, Irene L.: *Clinical Nursing, Pathophysiological and Psychosocial Approaches*; New York, The Macmillan Company, 1965, p. 1276.

⁶ *Ibid.*, p. 1276.

tration, diet, hygienic care of the feet and legs, and checking the urine for the presence of sugar.

Health teaching is a very important phase of nursing care, and must be included regardless of the disease. However, I feel that diabetic patients admitted to University Hospital are not receiving adequate teaching about their disease and how to care for themselves. I feel that this is due to the following reasons:

- A. the rising incidence of the disease,
- B. the many complex problems that the diagnosis of diabetes mellitus brings with it, and
- C. the amount of time involved in teaching the patient.

Review of Literature

Julia D. Watkins, instructor of public health nursing at the University of North Carolina School of Public Health and her associates have studied diabetic patients in their homes and have come up with some surprising facts. The following paragraphs are taken from this study.

Only four of 60 diabetic patients in a recent study demonstrated acceptable practices in insulin dosage, urine testing, meal content and spacing, and foot care.

They reported that 31 patients made errors in insulin dosage, 27 used urine tests in a way which would probably affect control adversely, 44 ate unsuitable meals unacceptably spaced, and 31 carried out poor foot care.

About one-third had inadequate equipment for insulin administration and 77 per cent sterilized the equipment inadequately—if at all. Most disturbing to the investigators were errors arising from use of the so-called “convertible” (U40-U80) syringe, with which, they said, a patient can make an error of 100 per cent; 28.5 per cent of those using the syringe made this error. Such errors could be prevented, the authors pointed out, simply by removing this syringe from the market.

Only one-third tested their urine correctly, and only 14 used the results to help regulate diet and insulin dosage. Twenty-seven performed the urine test and used it “in a way which would likely be detrimental to their diabetic control.”

Only 16 of the 60 patients were judged to have acceptable meals, reasonably spaced for a diabetic patient taking insulin.

Twenty-eight patients showed unacceptable management of their disease in three or four of the areas studied.⁷

The next paragraph is used specifically to point out the need for re-education of diabetic patients.

Duration of the disease did not appear to be related to knowledge, but the longer a patient had had the disease, the more errors he made in insulin

dosage. Duration and errors were significantly correlated at the 5 per cent level. Thirty-three per cent of those who had had diabetes for 10 years or less made errors, but almost 64 per cent of those having had it for more than 10 years made errors.⁸

Team Approach

South Nassau Communities Hospital in Oceanside, New York, has developed a team approach to the problems of diabetic patients. As a result, patients are receiving better care at less cost, the hospital is serving its community more effectively and staff members are deriving greater satisfaction from their work.⁹

The stimulus that led to this team approach was the recognition of the special needs of diabetic patients. It was stated that both the patient and his family need greater understanding of his illness so that their mutual health, physical and emotional needs may be met.

“The main purpose of the team approach is to prepare the patient to return to his family, community and former role while simultaneously managing his illness in a proper medical way.”¹⁰

This team approach has also been found to increase the knowledge, skills and teaching effectiveness of hospital personnel and medical staff, as well as promote a more timely referral to community agencies if the patient and family members are unable to grasp the information given at the hospital.¹¹

Members of the team include the patient's personal physician, the dietician, a nurse from the patient's nursing unit, and three representatives of the hospital's in-service education staff.

It is the patient's private physician who advises the other team members of the patient's needs and guides the team members in their individual roles and treatment for the specific patient.¹²

Dietary teaching is based on the patient's ethnological background and socio-economic level. It was recognized that the diet must be practical and suited to the realities of his existence and livelihood.¹³

The following paragraphs describe the different team members and the roles they play in the teaching of diabetic patients.

⁸ *Ibid.*, p. 266.

⁹ Coyne, June R. and Stolknocke, Richard: *Team approach to the problems of the diabetic patient*; *Hosp. Management* 103:82, April, 1967.

¹⁰ *Ibid.*, p. 83.

¹¹ *Ibid.*, p. 83.

¹² *Ibid.*, p. 83.

¹³ *Ibid.*, p. 83.

⁷ *Diabetic patients show poor disease management*; *Public Health Reports*, Washington, March, 1966, p. 266.

A nurse from the patient's nursing unit serves on the diabetic team so that nursing personnel may obtain a proper understanding of the patient's needs. They can then help the patient to cope with his problems as early as possible during his hospital stay.

Because the main functions of the diabetic team are basically educational for the patient, the hospital staff, the medical staff, and three representatives of the in-service education staff serve on the committee to develop and encourage the use of effective teaching techniques and aids. Each patient has his own level of learning ability which must be identified before the team can prepare the most effective approach to each patient.

The patient and his family and team members meet for a classroom discussion concerning the nature of the illness, the means of treatment and the problems of adjustment that must be made by the patient and his family. These general discussions are followed by individual instruction by appropriate team members. Instruction follows the course for the specific patient, predetermined by the entire team. The individual instruction stresses the importance of maintaining the proper diet developed for the patient, good personal hygiene through daily care, the preparation of medication and the testing of urine.¹⁴

This team approach has been found most effective at South Nassau Communities Hospital. Also, the services of the team have been extended to outpatients as a service to the community and the medical staff of the hospital. This outpatient service has been found to have eliminated the need for hospitalization in certain cases and has made beds available for *other* acute admissions.¹⁵

Teaching Diabetic Self-Care

The following article is taken from the *New England Journal of Medicine*.

Success in the treatment of diabetes depends to a large degree on the instruction of the patient in the management of the disorder under the conditions of his home life, his work, and his other activities. There is much for him to learn. The American Diabetics Association has presented as the basis for patient education a nine-point program including the following subjects: diet; tests of the urine; insulin and orally administered antidiabetic drugs; technique of insulin injection; care of the syringe and insulin; hypoglycemia, symptoms of uncontrolled diabetes and ketoacidosis; care of the feet (for older

patients) and emergencies. To teach all these things requires a *substantial* amount of work on the part of the physician and his assistants.

Among educational technics now undergoing trial to supplement and improve individual and group teaching is the use of autoinstructional devices or teaching machines. These devices present a combination of printed text and still pictures on a film strip; each frame is designed to show information in a manner that places emphasis on the salient points, together with a stimulus to discover and understand before the next frame is viewed.¹⁶

On the basis of the experience so far acquired at diabetic clinics in New England and in a number of other medical centers throughout the country, it cannot be claimed that the teaching machine is a panacea for all the problems of education of diabetic patients. It does appear, however, to be a superior teaching aid.¹⁷

St. Francis Hospital in Peoria, Illinois, has started using programmed material presented for study by means of a teaching machine. This program was developed by the Diabetes and Arthritis Program of the United States Department of Health, Education and Welfare. No material that has not been previously used in the teaching of diabetic patients is presented in this course. All the basic factual material needed by the patient is covered in this course. The purpose for adding the programmed instruction was not to provide additional information that had not previously been given, but to reinforce and strengthen the effectiveness of the teaching program by presenting the basic information in a new and different way.¹⁸

The addition of programmed instruction to their educational program has not reduced the number of their staff nor the hours spent in educational endeavor. Actually, the hours have increased, primarily due to the use of volunteers and non-professional help in scheduling and transporting the machine to the patients.¹⁹

Methodology

A. Definition of terms

Adequate—That which is no more than satisfactory; equal to or sufficient for some (specific) requirement.²⁰

Licensed Practical Nurse—a nurse who has obtained a license from a state, and who cares for the

¹⁶ *Teaching diabetic self-care; N. Eng. J. Med.* 276:182, Jan. 19, 1967.

¹⁷ *Ibid.*, p. 182.

¹⁸ Meadows, Dorothy: *Patients learn about diabetes from teaching machine; Hospitals J.A.H.A.* 39:77, December 16, 1965.

¹⁹ *Ibid.*, p. 80.

²⁰ *Websters' Third New International Dictionary; Springfield, Massachusetts, USA, G. and C. Merriam Company, Publishers, 1961, p. 25.*

¹⁴ *Ibid.*, p. 83.

¹⁵ *Ibid.*, p. 83.

sick professionally without having the training or experience of a registered nurse.²¹ (The main difference between a L.P.N.¹ and a R.N.² is that a L.P.N.¹ cannot administer medicines.)

Registered Nurse—a graduate nurse who has been licensed by a state authority (as a board of nursing examiners) after successfully passing examinations for registration.²²

Graduate Nurse—a person who has completed the regular course of study and practical hospital training in nurses' training school.²³

Clinical Specialist—I will define a clinical specialist by giving three features which should characterize her. She is a person who has advanced knowledge and skills in coping with the nursing care of patients who have similar disease entities, conditions, situations, or problems. She assumes full responsibility for the nature and quality of their nursing care and devotes all her attention and activity to this.²⁴

Whether the nursing care of a patient is given by her or another person, she must still assume full professional responsibility for the quality of care administered. She is the one who prescribes and carries out nursing care, guiding others in the care of a particular group of patients.²⁵

The specialist should have training beyond the baccalaureate degree. It is assumed that she is a nurse who wants to care for patients directly, rather than coordinate their nursing care through others.²⁶

B. Collection of data and sample

Questionnaires and interviews were used to collect data for the study, with the questionnaires being distributed to registered nurses, graduate nurses, and licensed practical nurses on six medical-surgical floors. The sample included 10 registered nurses, two graduate nurses, four licensed practical nurses in category one, seven licensed practical nurses in category two, and one "supervisor." This questionnaire was designed to determine whether or not nurses felt their diabetic teaching was adequate and the reasons for their answers. The role and purpose of a clinical specialist was defined and suggested as a possible solution to the problem.

A questionnaire was distributed to five physicians who were directly involved with treating diabetic pa-

tients. This questionnaire was designed to determine how doctors felt about the teaching their patients receive at University Hospital. They were also asked whether they felt it was the nurses' responsibility to teach diabetic patients and whether they felt nurses had the time to teach these patients. The clinical specialist was also suggested as a possible solution to the problem.

A questionnaire was developed to be used as a guide in interviewing diabetic patients, with the sample including 16 patients. The majority of the questions were designed to determine if patients felt they needed additional teaching.

Variables

I consider the honesty of the personnel my main uncontrolled variable. I feel that if some of the questions were structured differently this could have been controlled better. However, I did try to control this variable by stating in the questionnaire that this was not a test and no names would be used.

Another uncontrolled variable may be the terms used, as one person's definition of adequate may not be the same as another's. Also, I noted that two nurses were making comparisons while filling out the questionnaires. This may have influenced each person's responses. Some nurses may have viewed the questionnaire as a threat to them personally, and may have been biased when they answered the questions. Finally, I had no way of knowing whether the people filling out the questionnaires were really who they said they were.

I further tried to control the study in the following ways: (1) Patients were personally interviewed. By doing this, I was able to explain some of the material the patients did not understand. This also allowed me to determine whether I felt these patients needed additional teaching; (2) I tried to get a random sample by distributing questionnaires to nurses on all medical-surgical floors.

Discussion of Findings

I found that the majority (62 per cent) of the patients interviewed had been diabetic for less than 10 years. Thirty-eight per cent were diagnosed more than 10 years ago.

To my surprise, 62 per cent of these patients were taught by their doctors to care for their disease. Not one patient mentioned the nurse as the one who had taught them. However, a few stated they had been taught in the clinic.

Seventy-six per cent took oral hypoglycemics, 12 per cent took insulin, and 12 per cent were controlled strictly by diet.

Seventy-five per cent stated that they were on a special diet for their diabetes; however, only 19

²¹ *Ibid.*, p. 1780.

²² *Ibid.*, p. 1913.

²³ *Ibid.*, p. 985.

²⁴ Little, Dolores: *The nurse specialist*; *A.J.N.* 67:552, March, 1967.

²⁵ *Ibid.*, p. 553.

²⁶ *Ibid.*, p. 553.

per cent followed their diet all the time. Forty-four per cent stated that they used the diabetic exchange list, and 25 per cent did not know if they used the list in planning their diets.

Sixty-nine per cent checked their urine for sugar; however, only 19 per cent checked it three times a day, 7 per cent checked it twice a day, 31 per cent checked it at very irregular intervals, and 31 per cent did not check it at all.

Fifty-six per cent walked barefoot, 56 per cent of the patients used home remedies on their feet such as corn pads, iodine, and Mercurochrome. Eighty-one per cent did not know how to cut their toenails.

Fifty-six per cent of the patients interviewed felt they needed more teaching about their disease and how to care for themselves.

Interview Excerpts

The following paragraphs are taken from interviews with some of the patients.

Mr. A., a diabetic for more than five years, was on a diabetic bland diet. He spent approximately 15 minutes cursing the food and the dietary department. He stated that he was on a diabetic diet at home, but only followed it part of the time; he checked his urine for sugar three times a week. Mr. A. felt that he needed no additional teaching.

Mr. B. was diagnosed only a week prior to the interview. He had received dietary instruction from a hospital dietician. When asked how important he felt diet was in controlling diabetes he responded, "I guess it's important, that's what the man said." He had not been taught to check his urine for sugar and he walked barefoot, used home remedies on his feet, and cut his toenails "just any old way." Mr. B. felt he did not need any additional teaching about diabetes and its control.

Mrs. C., diagnosed in December, followed her diet, practiced good hygiene, checked her urine daily, and kept a record. When asked about the need for additional teaching she responded, "Yes, I do, constantly."

Mr. D. had been a diabetic "ever since I had a wreck in 1945." He had been on both oral hypoglycemics and insulin. However, he felt that vitamins did him more good than any of the antidiabetic medication on the market. He told me exactly how much of each vitamin he was taking. He stated that there was a lot about diabetes that people did not know. He followed his diet part of the time and "changed it every three days." He checked his urine for sugar according to what he ate. He stated that he cut his toenails "any way with a pair of scissors."

He felt he needed additional teaching because "no person never learns it all."

In general, the main area in which patients need additional teaching is in the care of their feet and legs.

From the results of this study, I feel that *all* patients interviewed need additional teaching and all patients, regardless of how long they have been a diabetic, need follow-up care. As stated before, 33 per cent of those who had had diabetes for 10 years or less made errors, but almost 65 per cent of those having had it for more than 10 years made errors in insulin administration.

Doctors' Questionnaire

From the doctors' questionnaire, the following results were found: Three out of five doctors questioned felt that diabetic patients at University Hospital were receiving sub-adequate teaching; four out of five doctors felt that the diabetic patient needed more teaching in the areas of insulin administration and dietary instruction; three out of five felt that patients needed to know more about the importance and procedure of checking the urine for sugar; five out of five felt that the nurses should teach the diabetic about his condition, and three out of five felt that the nurses had time to do this teaching adequately.

Several opinions of the doctors about the proposed solution follow:

"Would be helpful but this is mostly an office problem, and the primary responsibility of the physician."

"No need to hire specialists—treatment of diabetics should be fundamental knowledge of any licensed practical nurse or registered nurse."

"Excellent if we get the right nurse—terrible if we don't."

"Might work, but—"

"An M.D. should explain the disease and complications to the patients and tell them why we have them check urine for sugar and acetone, follow their diet, etc."

"Nurses should show and teach patients how to give insulin and check urine for sugar and acetone."

"Diet departments should work out a diet that the patient can follow and make sure they understand it."

Nurses' Questionnaire

In this questionnaire, I attempted to determine the amount of hours nurses spent teaching the newly diagnosed diabetic patient as compared to the previously diagnosed patient. One nurse responded by saying, "The total stay is a teaching process. To determine and give the number of hours is next to

impossible." However, four per cent said they spent from four to five hours teaching the diabetic patient, nine per cent spent from two to three hours, 64 per cent spent one hour or less and 23 per cent stated they spent no time teaching the newly diagnosed patient. Seventy-one per cent stated that they spent one hour or less teaching the previously diagnosed diabetic patient, and 29 per cent responded that they spent no time teaching the previously diagnosed diabetic patient.

Seventy-one per cent stated that they instructed the patient about his diet; however, 50 per cent felt that the dietary teaching should be left up to the dietician. Eighty-three per cent said they taught the patient to care for his feet and legs.

Ninety-six per cent said they knew how insulin worked in the body, 100 per cent stated that they knew the difference between hypoglycemia and hyperglycemia and 92 per cent knew how oral hypoglycemic worked. Seventeen per cent said that insulin could be taken by mouth; the "supervisor" was one of them.

Seventy-nine per cent felt that they did not have time to teach the diabetic patient all he needed to know about his disease and how to care for himself. Sixty-two and one-half per cent of the nurses felt they gave sub-adequate teaching to the diabetic patient and the other 37½ per cent marked adequate for this question.

Comments

The following are comments about the proposed solution:

"I feel this would be splendid, because sometimes we are too busy on the floor to really go into detail with the patient about his disease."

"Your proposed solution is a very good one, providing the clinical specialists also teach the auxiliary staff all about diabetes and how they can help."

"Patients would probably get a better understanding and more lengthy explanation of the disease because this specialist would have more time to explain their condition to them."

"No. I feel that more help should be hired to care for the patients on each floor, therefore giving the R.N. working with the patient daily, more time to do the teaching."

"I think the instructions should be for the attending physician, the reason being he will follow the patient during and after hospitalization while the nurse does not."

"I think it is a good idea. I love to teach patients but just don't have time."

"No, they should have adequate help on each floor that could handle these problems, without

having a specialist. I think this is very stupid and uncalled for."

"Should survey to see how many diabetics are in the hospital and it depends on the doctors, too. I feel this is the doctor's responsibility to teach diabetics the way he feels they should be treated. The patients are charged enough now without adding more charges to their bills. I always try to follow the doctor's instructions and try to teach the patient the best I can when he wants me to teach the patient. No two doctors treat their patient the same way and one person trying to teach all patients would bring confusion." (I disagree strongly with the above statement. First of all, if patients were taught how to care for themselves properly, many unnecessary hospitalizations could probably be avoided, saving the patient a great deal of money. Second, the principles of insulin administration, foot care, diet, and urine checking remain the same regardless of the physician treating the patient.)

Summary and Conclusions

This study has shown that the majority of nurses questioned at University Hospital felt that their teaching was not adequate to meet the needs of the diabetic patient. The time involved in teaching diabetic patients appeared to be the major factor that interfered with this teaching.

Germaine S. Krysan, in her article "How Do We Teach Four Million Diabetics," stated:

The education of a person with diabetes should continue throughout his lifetime. Regular medical supervision, adjustment in regimen, and continued guidance will be necessary if he is to meet change or stress. A large part of nurses' work is reinforcing what patients have already been taught. Even though a patient has had diabetes for 10 years, one cannot presume that he is skilled in self-care. People forget, or grow careless: They must be taught and retaught again.²⁷

Julia D. Watkins, in her article "Confusion in the Management of Diabetes," said:

Diabetic patients are expected to remember and to administer medication accurately at least once and sometimes several times a day. They must also make frequent tests of urine specimens, and consider the consequences of every bit of food they eat as well as to balance their food and medication with their activities. Errors made about insulin administration and even the diet may make the difference between being admitted to or staying out of the hospital, or even between life and death.²⁸

²⁷ Krysan, *op. cit.*, p. 107.

²⁸ Watkins, Julian D. and Moss, F. T.: *Confusion in the management of diabetes*; *A.J.N.* 69:3, March 1969.

DIABETIC ANALYSIS / Singleton

I feel that it is past time for something to be done about the problem of teaching diabetic patients. The following are suggested solutions:

1. Clinical specialist,
2. Programmed instruction and group teaching,
3. An in-service education program on teaching the diabetic patient,
4. The establishment of team nursing at University Hospital,
5. A better working relationship between members on the health team.

I feel that the establishment of a sound education program at University Hospital could reduce the number of complications resulting from uncontrolled diabetes in certain case, thereby allowing beds to be available for other acute admissions.

Other areas for possible investigation include:

1. The teaching that takes place in the physician's office,
2. A more specific determination of the hours (or minutes) nurses actually spend in teaching the patient,

3. The study of hospital patients in their homes to determine specifically if they really know how to care for themselves,

4. The use of program instruction in the hospital.

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13th ANNUAL

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Plan to Attend!

This paper describes wide dissemination of spontaneously occurring endometriosis in the Rhesus monkey and considers the remote, if even hypothetical, relationship of irradiation to the histogenesis of endometriosis.

Disseminated Endometriosis in a Rhesus Monkey (*Macaca Mulatta*)

HISTOGENESIS AND POSSIBLE RELATIONSHIP TO IRRADIATION EXPOSURE^{1, 2}

HAROLD M. MCCLURE, D.V.M., JOHN H. RIDLEY, M.D., and

CHARLES E. GRAHAM, Ph.D., *Atlanta*

THE HISTOGENESIS OF ENDOMETRIOSIS is an interesting subject for study and speculation. At least 11 theories of histogenesis have been published, and it is finally becoming more universally accepted that spread occurs by retrograde menstruation, direct extension and benign metastasis by blood and lymphatics.⁸

Spontaneous endometriosis occurs rarely in non-human subjects. It has been reported only in dogs (adenomyosis) and in nonhuman primates. The first case in a nonhuman primate was recorded by Fraser in 1929.¹ He noted endometrial tissue in the umbilical region, mesentery, sacro-uterine fold and the wall of the uterus in an adult female rhesus monkey. Joachimovits² reported a case of ovarian endometriosis in a *Macaca irus* the following year. Several additional cases have subsequently been reported in rhesus monkeys^{3-6, 9} and one case has been noted in a baboon.⁷

In most of the reported cases in nonhuman primates, the ectopic endometrial tissue was limited to the wall of the uterus or to adjacent organs. Apparently the most distant organs or tissue involved in previously reported cases of simian endometriosis have been the urinary bladder, ovary and umbilicus. Several of the reported cases have also occurred following surgical manipulation of the uterus. Of 21

cases recorded by McCann and Myers,⁶ 19 cases had a history of prior hysterotomy during pregnancy. The case recorded in this report is of particular interest due to the widespread dissemination of the ectopic endometrium, and the possible relationship of the condition to prior exposure to irradiation.

Case Report

An approximately nine year old, female rhesus monkey (*Macaca mulatta*) was noted clinically to show weakness, lethargy, and pallor. She had been exposed to 414 roentgens of cobalt irradiation at approximately one year of age. No remarkable clinical or physical abnormalities had been recorded during the intervening eight year period. No attempt had been made to breed the animal and no hormone therapy had been given during her time in the laboratory.

Menorrhagia, with increasing anemia, was noted and a mass was palpable in the lower abdomen. Due to her progressively deteriorating condition, the animal was euthanatized a few days after onset of the worsening status to facilitate collection of fresh tissue.

Significant gross findings at postmortem examination included: (a) a pelvic mass which was composed of uterus, adnexa, and colon; (b) blood-tinged ascitic fluid; (c) regional lymphadenopathy; (d) implants on the intestinal serosa and abdominal surface of the diaphragm; and (e) tumor-like nodules in the lung and liver (Figs. 1 and 2). One of the

¹Supported in part by NIH Division of Research Resources, Grant Number FR 00165 and Contract Number AF 41 (609)—2776.

²Yerkes Regional Primate Research Center, Emory University, Atlanta, Georgia.

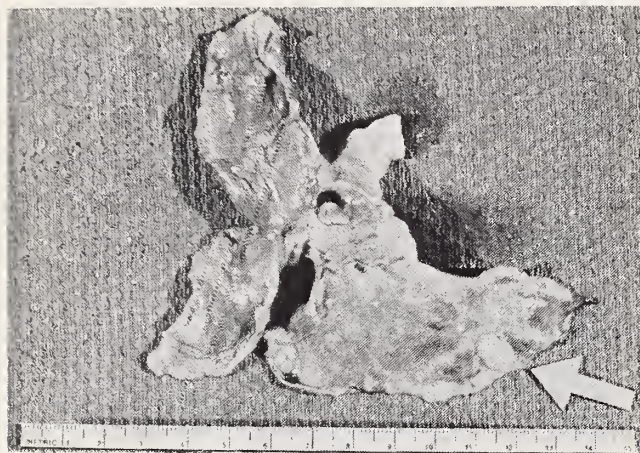


FIGURE 1

Subpleural nodule of endometrial tissue in the periphery of the right lower lobe of the lung (arrow).

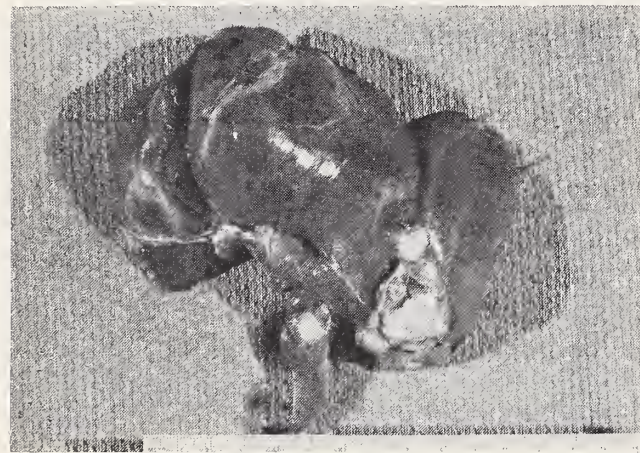


FIGURE 2

Endometrial nodules in the right, middle and caudate lobes of the liver (white areas at lower right).

nodules in the liver contained a small quantity of brownish, turbid fluid and had the appearance of a so-called “chocolate” cyst. The brain and other major organs were not involved.

Histologically, sections of uterus showed endometrial hyperplasia with diffuse hemorrhage and necrosis. The liver nodules consisted of typical endometrial-type glands embedded in a dense stroma. These lesions were, in most areas, completely surrounded by a dense connective tissue capsule. The glands contained variable amounts of red blood cells, fibrillar material, mononuclear cells and debris. Some showed desquamation of the lining epithelium (Fig. 3). The nodule in the lung had the same histologic features as that seen in the liver.

A similar histologic pattern was noted in the intestinal lesions (Fig. 4), and several lymph nodes contained similar glandular and stromal tissue. Numerous cysts of varying sizes were noted through-

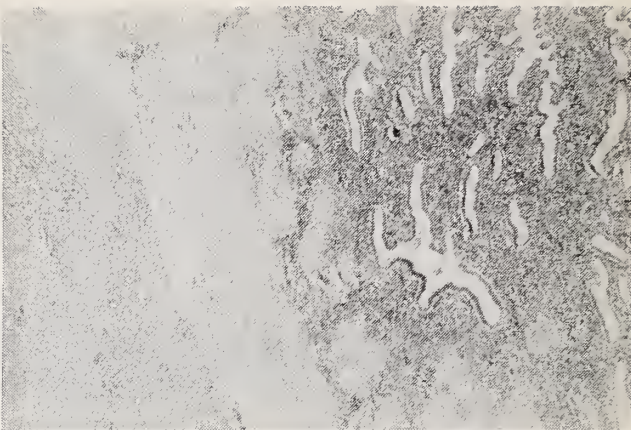


FIGURE 3

Photomicrograph of endometrial tissue in the liver. Note endometrial glands and stroma on the right, which are separated from the hepatic tissue by a dense band of connective tissue. H & E Stain; X 44.

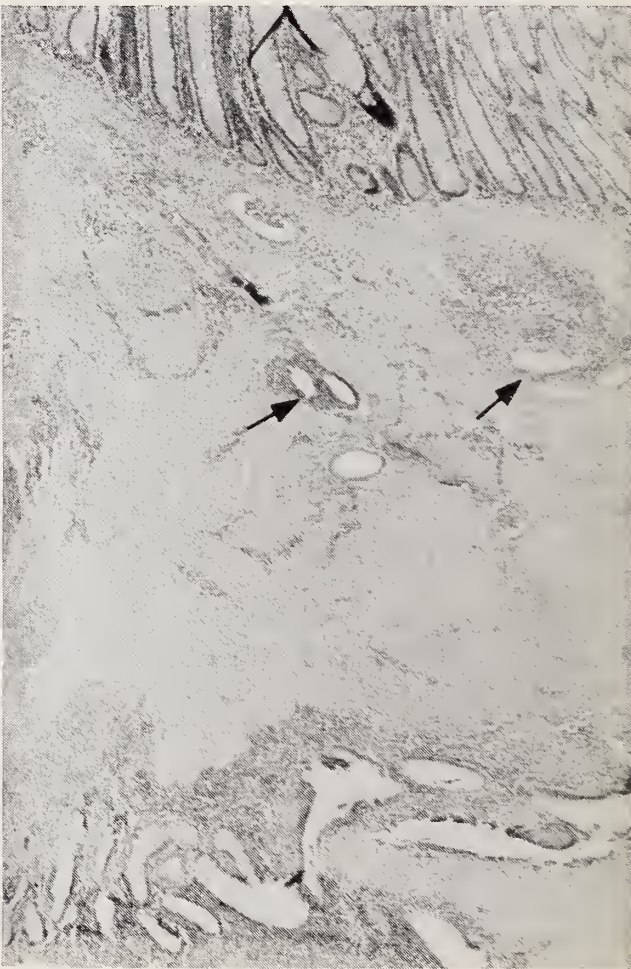


FIGURE 4

Photomicrograph of endometrial tissue in the wall of the colon. Note endometrial glands and stroma along the serosa (bottom) as well as deep within the muscle layers of the colon wall (arrows). H & E Stain; X 44.

out the involved lymph nodes (Fig. 5). In all tissues, the histologic features of the grossly observed nodules were that of essentially normal endometrial glands and stroma. Some glands showed a papillary pattern to the lining epithelium and stromal hyperplasia was noted in some areas.

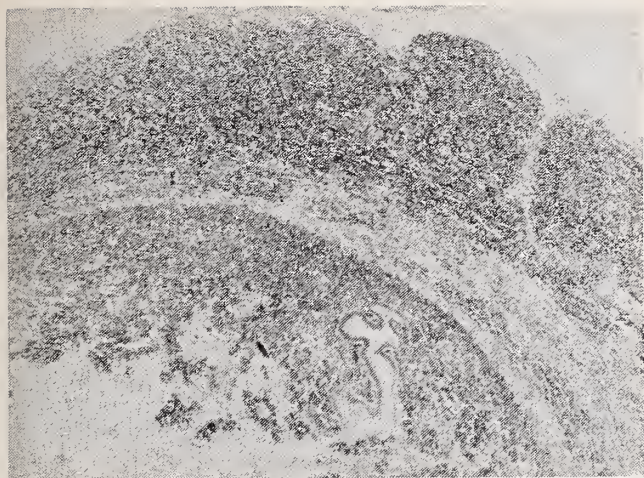


FIGURE 5

Photomicrograph of endometrial tissue in an abdominal lymph node. Note lymphoid tissue at the top and endometrial glands and stroma in the lower portion of the photograph. The central cyst-like space contains red blood cells and debris. H & E Stain; X 44.

Summary and Conclusions

A case of widely disseminated endometriosis in a rhesus monkey is reported. The pattern of dissemination observed provides evidence in support of the various modes of spread that are generally believed to occur in the human. Spread by direct extension appears to be represented by the presence of endometrial tissue in the wall of the colon, with adherence of the colon to the uterus. Spread by implantation is suggested by the presence of endometrial tissue on the serosa of the small intestine and on the diaphragm. Endometrial tissue in the lymph nodes, liver and lung, indicates metastasis by lymphatics and the vascular system. This case appears to represent the most widespread metastasis of benign endometrial tissue reported in the nonhuman primate, and as far as we can determine, is the only reported case of hepatic endometriosis in either man or nonhuman primate.

It is of further interest, although fanciful, that irradiation exposure might have some etiologic relationship to the subsequent development of endometriosis. We have observed a total of two cases of endometriosis and one case of adenomyosis in rhesus monkeys, all of which had a history of prior irradiation exposure. Two of 10 cases of endometriosis reported by Lapin and Yakovleva⁵ also had a history of irradiation exposure. Consequently, five of 21 cases (23.8 per cent) of "spontaneous" endometriosis reported in nonhuman primates have a history of prior irradiation exposure. The 21 cases considered are those cases observed in animals with no previous history of surgery involving the uterus.^{1-7, 9}

The fact that one-fourth of the cases of simian endometriosis, a relatively uncommon condition,

have occurred following irradiation exposure, suggests a possible relationship between irradiation and the subsequent development of endometriosis. Thus far, such a relationship has not been observed or reported in the human. Observations of the atomic bomb victims of Hiroshima have not recorded an increase in the incidence of endometriosis among the disorders of exposed women.¹⁰ Yet, one could speculate that the increasing incidence of endometriosis in the human may, in some way, be related to the increasing exposure of man to irradiation. Exposure to appropriate levels of irradiation could possibly alter the immunologic response of the host, and thereby enhance the extra-uterine location and proliferation of endometrial tissue.

1938 Peachtree Road, N.W. 30309

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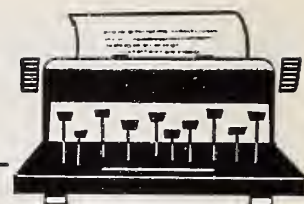
CALL FOR SCIENTIFIC EXHIBITS

117TH ANNUAL SESSION
OF THE
MEDICAL ASSOCIATION OF GEORGIA

Atlanta, Georgia, May 13-16, 1971

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman
MAG Scientific Exhibits Committee
938 Peachtree Street, N.E.
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Report on PSRO

ON FRIDAY, DECEMBER 11, 1970, the Senate Finance Committee reported out of its Committee to the Senate, H.R. 17550 (the Social Security Act of 1970) which includes Senator Bennett's Amendment establishing PSRO's (Professional Standards Review Organizations).

A PSRO would be a non-profit professional association (1), or a component organization thereof, which is composed of physicians engaged in the practice of medicine or surgery; (2) the membership of which includes a substantial proportion of all the practicing physicians in the area; and (3) which has professional competence to review the types and kinds of health care services for which the PSRO would have review responsibilities. If no such organization in the area met these requirements, the Secretary of HEW could designate some other public, non-profit, private or other agency or organization which had professional competence and was otherwise suitable to carry out these review activities.

It is expected that the Committee Report to accompany the bill will exclude a medical society as a PSRO, but permit the society to be instrumental in establishing such an organization. This would allow the Georgia Medical Foundation of the Medical Association of Georgia to function in the capacity of a PSRO.

Basic duties of the PSRO would be to review professional activities of physicians, other health care practitioners, and institutional providers under Medicare and Medicaid. Review would be made to determine whether: (a) the services are or were medically necessary; (b) the quality of the services meets professionally recognized standards; and (c) where services are provided on an inpatient basis, whether they could appropriately and effectively be provided on an outpatient basis or more economically on an inpatient basis in a facility of a different type. The PSRO would have authority, where it elects to do so, to determine in advance whether the above criteria will be met in the case of an elective admission to a hospital or other health care facility, or in the case of any other health care service which will consist of extended or costly sources of treatment. . . . The PSRO is directed to encourage all practicing physicians in the area to participate on a rotating basis in the review activities of the organization. . . . The Amendment calls for the development of regional norms of care and treatment based upon typical patterns of practice as principal points of evaluation and review. The Secretary is authorized to exclude a practitioner or provider from eligibility to provide services on a reimbursable basis under Titles XVIII and XIX, if he determines that the practitioner or provider has failed, in a substantial number of cases, to substantially comply with any obligations imposed on him or if he has grossly and flagrantly violated any of these obligations in one or more instances. The Amendment provides for a refund by the practitioner of an amount not in excess of the actual or estimated cost, up to \$5,000, of any medically improper or unnecessary services provided. The Amendment contains provisions protecting persons serving on PSRO against liability arising out of PSRO activity, and also for immunity to health care practitioners and providers acting in compliance with the professionally accepted norms of care and treatment where due care was exercised.

Eliminated from the bill are earlier provisions as to federal ownership of PSRO records, mandatory pre-admission approval for all cases of elective admissions (and now providing discretion in the PSRO to determine in which instances such approval will be required), provisions for a \$5,000 penalty and creation of national norms of care and treatment. Included in the modified Amendment is the provision, "No Professional Standards Review Organization shall utilize the services of any individual who is not a physician to make final determinations with respect to the professional conduct of any physician, or any act performed by any physician in the exercise of his profession."

The MAG has kept a close watch on this legislation and has communicated with Senator Talmadge on several occasions as authorized during the September 20th meeting of the MAG Council, which endorsed the Bennett Amendment in principle.

Because of time limitations, it is unlikely that the PSRO proposal will be enacted into law by Congress this year; however, there is still a slight chance of passage. Your MAG representatives expect to meet with Senator Talmadge in Washington to discuss the MAG support of the Bennett Amendment with reservations about some of its provisions, if the Senate approves the proposal and sends it to a House-Senate Conference Committee.

Doctor of the Day

THREE YEARS AGO the Medical Association of Georgia, spurred on by successes in other States, created a Medical Aid Station in the State Capitol to serve members of the General Assembly during their regular annual legislative sessions. The first year of operation was pretty much a "hit or miss" affair. Some days the Aid Station functioned and on others it did not. The facility, both space-wise and equipment-wise, left much to be desired. Nonetheless, in the eyes of the General Assembly it was an instant success and improvements made since that time have been considerable.

Staffing of the Aid Station has always been on a volunteer basis. Physicians from every corner of the State have volunteered their time and as a measure of the importance they attached to the program, more than half of the 1971 volunteer physicians are repeats from last year and the year before.

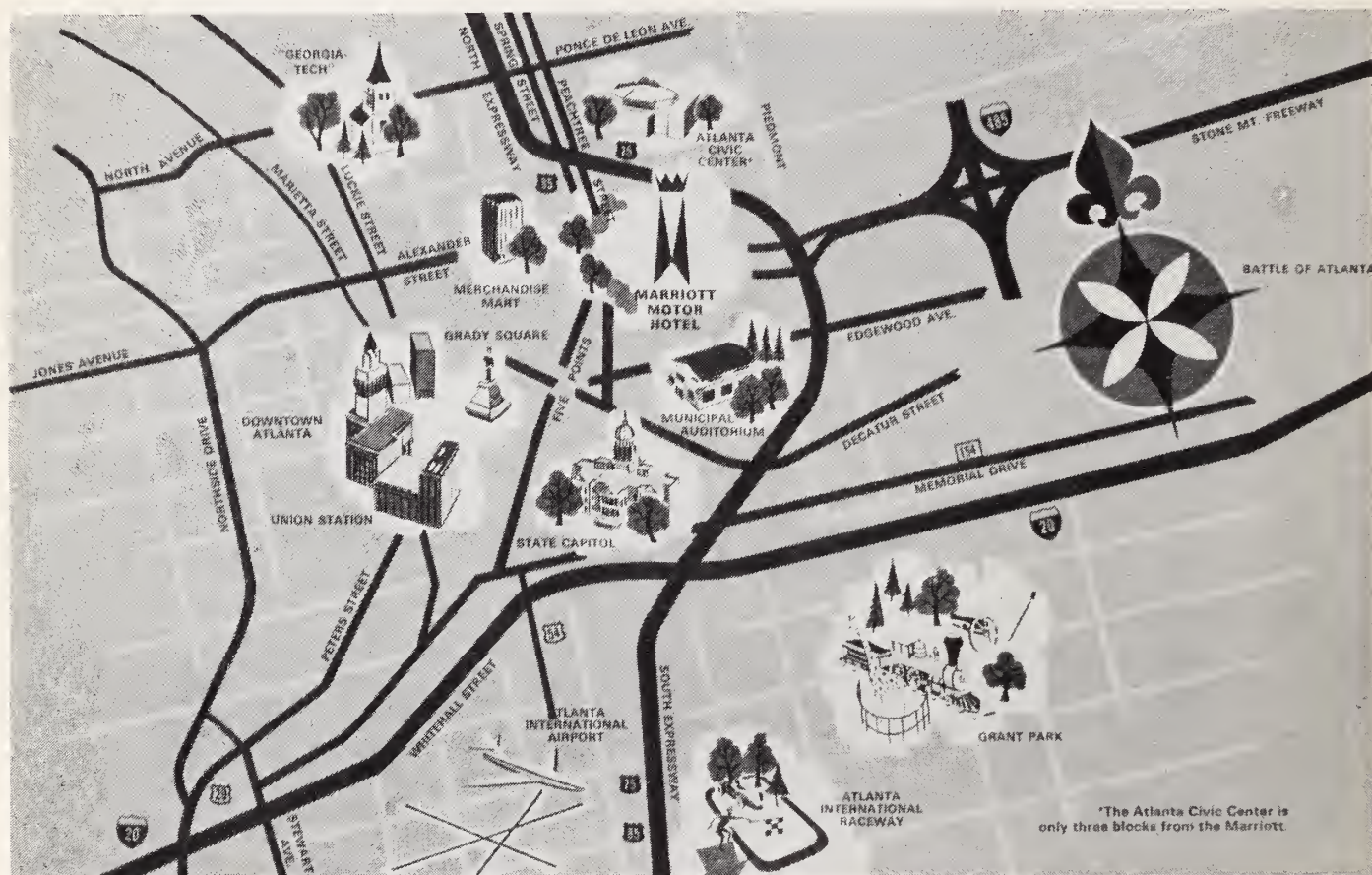
The purpose of the program is to furnish emergency and minor care to members of the General Assembly and thus help them to perform their jobs with a minimum loss of time due to illness. When one considers the fact that the Legislature will consider upwards of 1,500 bills and resolutions during their 40-day session, time loss on the part of any member becomes an important matter to the whole State.

Although the majority of those who come to the Aid Station complain of only minor ailments, occasionally a serious condition is detected in which case the Legislator's personal, hometown physician is notified. Arrangements with Atlanta-based specialists for referrals from the Doctor-of-the-Day for emergency conditions clearly beyond a level that can be handled effectively in the Aid Station have been made. Routine EKG's are taken on all those who come by the Aid Station and are mailed to the Legislator's personal physician soon after adjournment.

The program has achieved great popularity with the membership of the General Assembly as the resolutions that have been adopted each year, commending MAG and the physicians, testify. Aside from the public relations advantages of this program, which are obvious, the Doctor-of-the-Day project is worthwhile for its own sake.

Your *Journal* wishes to commend all those who have participated in this program as being a part of what might well be MAG's most effective public relations endeavor.

Come to Atlanta in May



THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 13, 1971

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 14, 1971

- 9:00 a.m.—First General Session
First Session, House of Delegates
General Meeting
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—Health Care"

- 6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 15, 1971

- 9:00 a.m.—Reference Committee Meetings
- 9:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—The Drug Scene"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 16, 1971

- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia

Annual Session

May 13-16, 1971—Atlanta, Georgia
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A RECOMMENDATION

DURING THE PAST SEVERAL MONTHS, there have been many instances of reduction in payment to physicians by the Prudential Insurance Company for services rendered to individuals covered under the Medicare Program. This has resulted in frustration and anger. The "printout" on the explanation of Medicare benefits was so worded that the implication, in effect, indicated an overcharge by the physician. This resulted in a delay in payments and requests for information brought inadequate and confusing replies.

According to records in the MAG Headquarters, some 81.1 per cent of Georgia physicians were accepting assignment of benefits as of August 31, 1970. In October, 1970, each member of MAG received a letter from the President's office suggesting members not accept assignments, thus preventing further loss of income from the reductions.

At the inception of the Medicare Program, John Hancock Insurance Company entered into a contract with HEW to administer the program for payment of physicians' fees. When John Hancock Insurance Company chose not to renew its contract, the Prudential Insurance Company replaced them April 3, 1970 with essentially the same contractual agreement. Where John Hancock had processed claims manually and paid claims on the basis of the most frequent charge rendered, which approximated usual and customary fees, Prudential followed the same procedure. Following installation of a total computerized system, there was a reduction of some fees based on "prevailing fees" (see box). The prevailing fee limitation is based, therefore, on physicians' fees as of December 31, 1968.

The Medicare Program is simply an indemnity insurance agreement between the Department of HEW and every person age 65 and over, and is on a voluntary basis. At its inception, the premium was \$3.00 per month for each "policy holder" and this was matched by HEW. The present premium is \$5.30 per month. Indemnity is 20 per cent for recipient and 80 per cent for HEW based on "prevailing fees" of December 31, 1968. The physician who accepts assignment is bound by law to bill only for the 20 per cent of the carrier's reasonable charge determination (after deductible has been satisfied). If the physician bills his patient directly for usual and customary fees and gives the patient a receipt, reimbursement is made directly to the patient by Prudential. Such reimbursement is in accordance with the agreement between the Medicare policy holder and the insurer—HEW. The physician should not be involved other than through his aid in supplying the patient with proper information for the submission of his claim. This is in accordance with the policy of submission of information applicable to any other insurance program.

Executive Committee, on October 11, 1970, requested a meeting composed of MAG Officials and representatives of the Prudential Insurance Company, the Social Security Administration and the Bureau of Health Insurance for clarification of regulations regarding payment of fees under the Medicare Program. This report is based on results of these meetings. Each of these representatives have been helpful and open-minded.

The determination of the reasonable charge takes into account both of the following factors:

(1) The customary charge for similar services generally made by the practitioner. This term refers to the amount which the individual practitioner usually and most frequently charges his patients for a specific service in similar medical circumstances. The reasonable charge would not be higher than the individual practitioner's customary charge. The customary charge for different practitioners, of course, may vary.

A practitioner's customary charge is not necessarily a static amount. Where the practitioner alters his charges for his patients generally, his customary charges change; accordingly, these charges would be recognized in determinations of reasonable charge for the services he renders to Medicaid recipients.

(2) The prevailing charges in the locality for similar services. This term refers to those charges which fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. Prevailing charges are derived from the overall pattern existing within a locality.

A "locality" is the geographical area for which prevailing charges for services may be derived. It may be a political or economic subdivision of a State, but it does include a cross-section of the population with respect to economic and other characteristics. Localities may differ in population density, economic level, and other major factors affecting charge for services.

The range of prevailing charges in a locality may be different for practitioners who engage in specialty practice than for those who are engaged primarily in general practice. Existing differentials in the level of charges between different kinds of practice could, in some localities, lead to the development of more than one range of prevailing charges for application in the determination of reasonable charges.

A charge which exceeds either the customary charge of the practitioner who rendered the medical or other health service, or the prevailing charge in the locality, or both, may be found to be reasonable, but only where there are unusual circumstances or medical complications requiring additional time, effort or expense which support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. On the other hand, the mere fact that the practitioner's customary charge is higher than the prevailing would not justify a determination of reasonable charge higher than the prevailing charge.

The Physician's Reference Manual

In summary, if a physician chooses to accept assignment, he must abide by the rules established and thereby lose money if his charges exceed the "prevailing." If he chooses to act as a free agent and maintain a purely doctor-patient relationship, he should do so, at all times keeping the welfare of his patient paramount, aiding him in securing just reimbursement by and under whatever program of reimbursement available.



F. G. Eldridge, M.D.
President, Medical Association of Georgia

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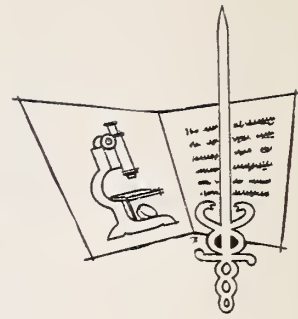
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NON-HORMONAL TREATMENT FOR CANCER OF THE BREAST

JAMES A. BUTTS, M.D., *Gainesville*

NON-HORMONAL TREATMENT for cancer of the female breast is indicated when various forms of hormonal manipulation are ineffective, when survival is expected to be less than four to six weeks, or when there is lymphangitic pulmonary metastasis, massive liver involvement, or inflammatory skin recurrence.

Chemotherapy in the treatment of this disease has been used with varying degrees of success. It is important to be familiar with the general physical condition of the patient, particularly the hematological, hepatic, and renal status prior to instituting these drugs. Some knowledge of the toxicity of the drugs, their effect on the various systems of the body and consideration of drug dosage, particularly in previously irradiated patients, is important.

Alkylating agents have been used in the past with some degree of success; however, most studies have obtained only a brief response to these drugs in about 25 per cent of the patients. The choice between thiophosphamide (ThioTEPA), nitrogen mustard, or cyclophosphamide (Cytosin) depends on factors related to method and rate of administration more than any difference in activity. The main advantage of these drugs is the rapid effect. The recommended dose of cyclophosphamide is 40 milligrams per kilogram IV every three weeks or 2-3 milligrams per kilogram by mouth daily. Thiophosphamide is given in a dose of 1 milligram per kilogram per week IM or IV, or .5 milligrams per kilogram per day for five days.

Better results have been obtained with the use of 5-fluorouracil. This has been especially evident for patients less than one year postmenopausal. It is my opinion that if time allows, this is the best course of treatment to offer in addition to, or in place of, hormone therapy.

An initial dose of 5-fluorouracil of 12 milligrams per kilogram given IV daily for four days and then followed by 500-1000 milligrams weekly is relatively free of toxic symptoms. This drug may be supplemented by Prednisone, which in turn improves the sense of well being of the patient, reduces the serum calcium in those patients in whom calcium elevation occurs, and has been suspected to indirectly have some effect on metastatic cells.

Alternate Measures

If this treatment plan fails, then Methotrexate or Methotrexate plus androgens and/or corticosteroids may be used. Methotrexate in a dosage of 1.25 to 2.5 milligrams every six hours for 20 doses by mouth or 30 milligrams per meter squared twice weekly by mouth has achieved remissions in approximately 50 per cent of patients. The above mentioned course is repeated when toxicity subsides, usually

in 14-28 days. The dose must be altered to avoid severe toxicity such as marrow depression or mouth ulceration.

Another drug which has been found to be of value is vincristin (Oncovin) in a dosage of 1-2 milligrams weekly IV. Vinblastin (Velban) has also been occasionally effective, the IV dose being .1-.2 milligrams per kilogram weekly. The dosage of these drugs is limited by the development of their toxic side effects, particularly neurological symptoms with Oncovin and leukopenia with Velban.

In many chemotherapeutic centers around this country, combination programs are popular and possibly represent a superior mode of therapy. These treatment programs combine oral Prednisone with oral or IM Methotrexate, oral cyclophosphamide, IV 5-fluorouracil and vincristin. As would be expected, some degree of skill and experience in the use of chemotherapeutic agents is needed since these protocols may well be associated with severe toxic reactions from the drugs used. With present methods, treatment of patients with metastatic carcinoma of the breast is unsatisfactory.

Only about 25-30 per cent of such patients respond to the administration of androgens or estrogens. It may be that a combination chemotherapeutic program is indeed the most effective non-hormonal plan available; however, further studies must be done to evaluate these programs and to delineate the appropriate drug dosage schedule.

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ANESTHESIA AND CARDIAC PATIENTS

PERRY P. VOLPITTO, M.D.,* *Augusta*

ANESTHESIA, WHETHER GENERAL, REGIONAL OR LOCAL, is life-threatening to a poorly controlled cardiac patient. On the other hand, the risk of properly managed anesthesia is minimal to the cardiac patient, provided that: (a) the heart is compensated; (b) arrhythmias, especially those that may interfere with cardiac output, are under reasonable control, (c) hypertension or hypotension is relatively well controlled so that organ and tissue perfusion is not hampered and (d) the blood gases, serum electrolytes, hemoglobin and hematocrit, are relatively normal.

All commonly used general and local anesthetics are capable of affecting the circulation in some manner: (a) by directly depressing the myocardium, (b) by interfering with the conduction system of the heart, or (c) by affecting the peripheral circulation either through vasomotor centers, or by increasing catecholamine response. It is imperative that the anesthesiologist be aware of the patient's cardiac status, and that he have expertise in cardiovascular physiology and pharmacology.

Several retrospective studies have been reported on patients with coronary artery disease and documented myocardial infarction prior to anesthesia and surgery. The hazard of anesthesia and surgery is increased five to ten-fold in the patient who has had a previous transmural infarction versus a subendocardial infarction. In addition, a patient with a documented myocardial infarction preoperatively who developed a second myocardial infarction postoperatively appeared to have only about one chance in three of surviving. The authors are in agreement that elective surgery should be postponed at least three months, and preferably a year or more following a myocardial infarction. In these reports, as in our experience, properly managed anesthesia did not play a significant role in the myocardial infarction.

Postponement Indication

Digitalis intoxication is an indication for postponement of anesthesia unless a bona fide emergency exists. The possibility of the anesthetic agents adding to the pre-existing myocardial depression is a very real hazard. Preoperative digitalization of the cardiac patient, when necessary, should occur over several days. Rapid digitalization should be reserved for emergency situations. The practice of partially digitalizing poor risk patients prior to anesthesia for surgery of high magnitude is recommended. This applies especially to the arteriosclerotic patient with impaired pulmonary function.

Anesthesia is especially hazardous for patients who are to undergo surgery for coronary heart disease. The anesthesiologist must insure that the patient is in optimum cardiac condition, and that the patient's anxiety is controlled with proper preanesthetic sedation. Respiratory and circulatory depression should be minimal. The anesthesia should be maintained in a light plane. In addition to the usual monitoring (ECG, esophageal stethoscope, blood pressure and body temperature),

* Professor and Chairman, Department of Anesthesiology, Medical College of Georgia, Augusta, Georgia.
Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

blood gases and intra-arterial blood pressure should be frequently assessed during the procedure, and aberrations in blood pressure, PaO₂, PaCO₂, and pH should be promptly corrected.

Pre-surgical consultations on the cardiac patient are advisable. The internist or cardiologist can contribute materially to preparing the patient from a cardiac standpoint. The anesthesiologist should also be consulted. The choice of premedication and anesthesia should be left to the anesthesiologist.

Anesthesia, when properly managed, rarely plays a major role in intraoperative or postoperative deaths. The period of induction of anesthesia is generally the most hazardous period for any patient. When anesthesia is well established and surgery has begun, complications are most commonly related to magnitude of surgery, expertise of the surgeon, and length of surgery.

In conclusion, the important factors in the successful operative management of any patient include proper preparation of the patient and competence of the operating team of nurses, surgeons, and anesthesiologist. In addition, a well-staffed recovery unit and postoperative intensive care area will assure any patient a much greater chance for a successful outcome.

Medical College of Georgia 30902

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Jack H. Hall, M.D., Indianapolis, Ind.
General Practice
Denis Cavanagh, M.D., St. Louis, Mo.
Gynecology
John T. Galambos, M.D., Atlanta, Ga.
Internal Medicine
Roger F. Palmer, M.D., Miami, Fla.
Internal Medicine
Nathan S. Schlezinger, M.D., Philadelphia, Pa.
Neurology

Ernest W. Page, M.D., San Francisco, Calif.
Obstetrics
Henry F. Allen, M.D., Boston, Mass.
Ophthalmology
Phillip L. Day, M.D., San Antonio, Tex.
Orthopedic Surgery
Edley H. Jones, M.D., Vicksburg, Miss.
Otolaryngology
John A. Shively, M.D., Columbia, Mo.
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PERTINENT INFORMATION ABOUT STATUTES OF LIMITATION

JOHN L. MOORE, JR., *Atlanta**

EVERY STATE HAS ENACTED STATUTES OF LIMITATION fixing the time periods after which rights cannot be enforced by legal action. The following comments are general statements of Georgia law in this highly technical area. Please note that when dealing with statutes of limitation, each factual situation must be viewed independently and the analysis below is meant only as a general guideline.

In Georgia, physicians may be sued for malpractice in either breach of contract or negligence actions. A contract to provide competent medical care may be written, oral, or implied from the parties' course of conduct. An action for the breach of a written contract may be initiated within six years after the debt has become due and payable, while suits based on oral or implied contracts are barred four years after the debt has become due and payable. Negligence actions, entirely independent of contracts and authorized by state law which provides that one treated by a physician has a right to expect him to exercise a reasonable degree of skill and care, must be brought within two years after the negligent act occurred. A patient's suit for wrongful death differs slightly from the usual negligence action, since in wrongful death cases the two year statute runs from the date of death.

Performing an unauthorized operation or failing to secure the informed consent of the patient is similarly violative of the physician's legal duty to the patient. Such conduct by the physician constitutes a battery and suits of this nature must likewise be initiated within two years of the wrongful act.

Extenuating Circumstances

There are two important situations which can prolong the period during which the physician may be sued. If the patient is a minor or an insane person at the time of the physician's breach of contract or negligence, the statutory period does not begin to elapse until the minor patient attains adult status or until the insane patient becomes lucid. The other circumstance which suspends expiration of the statutory period is the situation where the physician deceives or fails to inform the patient about his condition. This arises in cases where the physician fraudulently conceals the effect of treatment or that he has failed to treat (as when the presence of a foreign object in the patient's body known to the physician is not disclosed to the patient).

Statutes of limitation also govern the time during which physicians may sue to collect delinquent accounts. The general rule is that such suits may be brought within four years after the termination of services. However, problems arise in

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

situations where no fixed period or definite total amount is agreed upon, but rather care is provided on a continuing basis contingent upon the patient's needs. Often courts construe such contracts as "severable" and those services provided more than four years ago may be viewed as separate transactions upon which medical care has ended. Therefore, such rendered services are no longer the basis of a lawsuit. A precautionary bookkeeping practice, to protect against such a construction of the contract by the court, is specifically to apply undesignated payments in satisfaction of the oldest items of account in an effort to keep the unsatisfied items comprising a patient's account less than four years old.

Suite 1220, C & S Bank Building

HIGHLIGHTS OF THE MAG COUNCIL MEETING DECEMBER 12-13, 1970

Finance: Approved an additional appropriation from the contingency fund to offset an increase in property taxes.

Appointments: Nominated Donald R. Roberts, M.D., Brunswick, for appointment to the Coastal Area Comprehensive Health Planning Council.

Georgia Medical Care Foundation, Inc.: Approved the Bylaws of G.M.C.F.I. and adopted the slate of Board nominees presented by the Executive Committee.

MAG Foundation: Designated Executive Committee to receive a written proposal from M.A.G.F. on County Society contributions for indigent members.

Certification of Need: Voted to vigorously oppose legislation requiring a certification of need in locating hospital facilities.

Podiatry: Requested that the Committees on Legislation and Professional Conduct meet with representatives of the Georgia Orthopedic Society, the Attorney General's office and MAG Legal Counsel to propose a policy on hospital staff appointments for Podiatrists and define the scope of Podiatry practice.

Maternal and Infant Welfare: Heard an advance report on the results of the MAG survey on abortion to be published in the December *JMAG*. Also heard in the report from the Board of Health that the Department will adopt effective January 1 the expanded birth certificate form recommended by MAG.

Constitution and Bylaws: Approved for submission to the House of Delegates recommendations of the Committee on Constitution and Bylaws 1) to have Life Members included in the count of active members for County Delegate apportionment, 2) Executive Committee approval for acceptance of original jurisdiction in matters referred to the Committee on Professional Conduct, and 3) Provision for convening the House of Delegates for emergency consideration of Presidential succession. Also designated the Commit-

tee on Constitution and Bylaws as the appropriate body to review County Society Bylaws revisions.

Usual, Customary or Reasonable Fees: Adopted a resolution calling on Georgia health insurance carriers to promote more aggressively their UCR contracts.

Licensure: Adopted a policy supporting the citizenship requirement for Georgia license.

Next Meeting: Macon Hilton, March 20-21, 1971.

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THE ASSOCIATION



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Boyd, Claud A., Jr. Active—Richmond—D	1509 Anthony Road Augusta, Georgia 30904
Carter, James A. Active—Fulton—OTO	1938 Peachtree Rd., N. W. Atlanta, Georgia 30309
Daitch, Ronald DE-2—Richmond—OBG	Talmadge Memorial Hospital Augusta, Georgia 30902
Dunlap, Dickson B. Active—Richmond—I	VA Hospital Augusta, Georgia 30904
George, William M., Jr. DE-2—Richmond—OBG	Talmadge Memorial Hospital Augusta, Georgia 30902
Haston, Hugh B., Jr. Active—C. W. Long—OR	125 King Ave. Athens, Georgia 30601
Kibler, James A. Active—Laurens—P	420 Academy Ave. Dublin, Georgia 31021
Mason, Edward McK. DE-2—Fulton—SU	300 Boulevard, N. E. Atlanta, Georgia 30312
Owen, Ralph G. DE-2—Richmond—OBG	Talmadge Memorial Hospital Augusta, Georgia 30902
Payne, Pete M. DE-2—Richmond—OBG	Medical College of Georgia Augusta, Georgia 30902
Sanders, F. Hunt Active—Peach Belt—GP	212 Hospital Drive Warner Robins, Georgia 31093
Schmitt, Elbert W., Jr. Active—Fulton—OR	1365 Clifton Road, N. E. Atlanta, Georgia 30322
Stambuk, Robert B. Active—Ogeechee River— R	Bulloch County Hospital Statesboro, Ga. 30458
Talledo, O. Edwardo Active—Richmond—OBG	1507 Anthony Road Augusta, Georgia 30904
Thurmond, George W. Active—Richmond—OTO	1021 15th St. Augusta, Georgia 30901
Watkins, Philip B. Active—Richmond—PH	1001 Bailie Drive Augusta, Georgia 30901

PERSONALS

Second District

F. Dempsey Guillebeau and **Charles D. Hollis** have been named members of the American College of Physicians.

Third District

Joseph T. Christmas has been re-elected to active membership in the American Academy of General Practice.

Fourth District

Luther M. Vinton, Jr., has been re-elected to active membership in the American Academy of General Practice.

Fifth District

James A. Alford has become the first person to receive an appointment as assistant dean of both the medical and nursing schools of Emory University. He received his appointments in December.

Joseph Hertell spoke on "Drugs and Drug Abuse" at Cedartown High School in December.

William A. Hopkins was guest speaker at the regular meeting of the Cedartown Exchange Club in November.

Lester Rumble of Palm Desert, California, formerly of Atlanta, was appointed Associate Clinical Professor of Medicine at Loma Linda University School of Medicine in Riverside, California.

Seventh District

Virginia Hamilton spoke on the problems of living in a drug-oriented society at the Sans Souci Club, Cartersville, in November.

Ninth District

Kenneth Conoley has joined the Toccoa Clinic Medical Associates for the practice of pediatrics.

DEATHS

Ernest E. Proctor

Ernest E. Proctor, 42, chief of staff at Coweta General Hospital and secretary of Newnan Hospital, died November 18 in a private hospital in Newnan.

Born in Milan, Dr. Proctor attended Emory at Oxford, Emory University and Emory University Medical School. He was a Phi Beta Kappa and a member of Alpha Omega medical fraternity.

He interned at the Veterans Hospital in Atlanta and the Presbyterian and Women's Hospital in Pittsburgh, Pa. He held a fellowship in cardiology at Emory University.

He was a past president of the Sixth District Medical Society, a councilor for the Medical Association of Georgia, a member of the American Board of Internal Medicine, a director of the Georgia Heart Association, an assistant fellow of the American College of Physicians and a volunteer instructor at the Emory University School of Medicine.

ASSOCIATION / Continued

Dr. Proctor was chairman of the Republican party in Coweta County and was a member of the state central committee of the Republican party. He was also a director of the Oak Mountain Academy.

He was a veteran of World War II, a deacon at the First Baptist Church of Newnan and a member of the Newnan Country Club and the Capitol City Club in Atlanta.

Dr. Proctor is survived by his widow, two sons, a daughter, his mother and a brother.

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL DECEMBER 12, 1970

Appointments: Announced as appointed by Governor Maddox to the Board of Health were P. K. Dixon, M.D., Gainesville, 9th District, and James K. McDonald, M.D., Augusta, 10th District. Announced as appointed to the Board of Health Committee on Clinical Laboratories, John S. Atwater, M.D., Atlanta. Appointed John H. Reed, Jr., M.D., Gainesville, to Legislative Committee. Recommended to Council the nomination of Don R. Roberts, Jr., M.D., Brunswick, for affiliate member, Coastal Area Comprehensive Health Planning Council.

Peer Review: Adopted the following language for inclusion in the Committee on Medical Review and Negotiating Manual:

"SUBMISSION CRITERIA

Third Party Carriers should submit to medical review all claims which exceed usual and customary charges based on the Carrier's physician profiles, and all claims which exceed the utilization parameters as designed by the Committee. Physicians may also submit claims to medical review which in their judgment have been handled in an unreasonable manner."

Allied Health Professions: Assigned to the Committee on Allied Health Careers responsibility for assisting the Association of Schools of Allied Health Professions with arrangements for their 1971 annual meeting to be held in Atlanta, November 3-6.

Georgia Medical Care Foundation, Inc.: Nominated to Council the following slate for Directors of G.M.C.F.I.:

John Kirk Train, Jr., M.D. (Oph.), Savannah, Past President

Donald McKenzie, M.D. (Urol.), Thomasville, Vice Councilor

Joe T. Christmas, M.D. (G.P.), Vienna, Councilor

L. C. Buchanan, M.D. (Surg.), Decatur, Vice Councilor

F. W. Dowda, M.D. (Int.), Atlanta, 1st Vice President

Norman Gardner, M.D. (G.P.), Thomaston, Councilor

David Wells, M.D. (G.P.), Dalton, Councilor

F. G. Eldridge, M.D. (Rad.), Valdosta, President

Henry Jennings, M.D. (Int.), Gainesville, Alternate AMA Delegate

A. Joseph Green, M.D. (Ped.), Augusta, At Large

John R. McCain, M.D. (Ob-Gyn.), Atlanta, At Large

Publications: Decided to invite Editors of County Medical Society Bulletins and the *JMAG* to meet in conjunction with the Executive Committee of Council, January 17, to discuss medical communications in Georgia.

Next Meeting: Sunday, January 17, 1971, MAG Headquarters.

1971 ATLANTA GRADUATE MEDICAL ASSEMBLY

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THE MONTH IN WASHINGTON

Rep. Wilbur D. Mills (D., Ark.) expressed concern about claims that prepaid group health care, or health maintenance organizations, could solve most of the problems of medicare and medicaid.

Speaking to a group of business executives, the chairman of the House Ways and Means Committee, which handles medicare and medicaid legislation, said that he believed health maintenance organizations were "a reasonable and perhaps competitive alternative" for providing government-financed health care.

"However," he added, "I have become concerned that we will expect a great deal more from them than is likely to occur. The health industry is too diversified and its problems too complex to ever conclude that any one approach will solve most or all of the problems."

Rise in Spending

Americans broke a spending record for health care this past year, paying out about \$70 billion for everything from aspirin to hospitals, Mills also said. Inflation accounted for half the boost of about 16 per cent over the \$60.3 billion spent in the previous fiscal year, he said.

Mills said he expects health care spending figures for fiscal 1970, which ended July 1, would show that \$7 out of every \$100 spent in the United States for all goods and services went for health expenditures. "Just three years ago," Mills said, "it was estimated that we would not reach the 7 per cent level until 1975."

He noted, however, that the fiscal 1970 figures would show "for the first time" that federal spending did not increase as fast as private spending for health services.

"The reason for this development is that the medicare program did not grow as fast as it had been growing," Mills said.

Mills said the new health care figures point out two major characteristics of the health industry—"rapidly escalating costs and rapidly increasing public involvement."

"Public funds now pay for one-half of all the hospital care provided in the country," Mills said. "Medicare and medicaid together account for almost all of the half."

NHI Issue

National health insurance is shaping up as one of the major domestic issues before the 92nd Congress with catastrophic illness coverage gaining support from both Democrats and Republicans.

Advocates of catastrophic coverage counted on the Nixon Administration supporting such a plan, although Elliot L. Richardson, secretary of Health, Education, and Welfare, called for its rejection at that time when it unexpectedly was placed before the Senate Finance Committee in executive session late last year near the end of the 91st Congress. But he left the door open for Administration support later.

"A proposal with this impact on the health care system deserves the closest kind of examination, not the

hasty look it has been given in the waning days of an executive session," Richardson said.

The secretary's comment was in response to the surprise announcement by Sen. Russell B. Long (D., La.) that he would offer a catastrophic illness coverage plan to the finance committee of which he is chairman.

Social Security Increase

Long's plan called for the government to pay 80 per cent of all medical costs beyond the first 60 days of hospitalization or the first \$2,000 of physicians' bills for all Americans who pay social security taxes and are under 65. He estimated the cost at \$2.5 billion a year to be financed by a one-half of one per cent increase in social security taxes, to be shared equally by employers and employees.

The American Medical Association also cleared the way to add catastrophic coverage to its Mediredit plan for voluntary national health insurance. The House of Delegates at the AMA 1970 clinical convention in Boston approved a report of the Board of Trustees listing catastrophic coverage among the modifications and improvements being considered before reintroduction of the Mediredit legislation.

All national health legislation introduced during 1969-70 died with the final adjournment of the 91st Congress, and some modifications were expected to be incorporated in most of the leading proposals before their reintroduction in the 92nd Congress.

Hall's Proposal

Rep. Durward G. Hall (R., Mo.), a physician, introduced during the final months of the 91st Congress legislation that would establish a government program of catastrophic illness insurance for all Americans along with a program of basic health care protection for the medically indigent.

Part A (Basic Protection) of Hall's proposal would replace the present medicaid program. Each state would be authorized to determine the level of medical indigence in that state and to purchase, from private carriers, basic health insurance coverage for the medically indigent. The states would receive federal reimbursement for 85 per cent of the costs incurred in providing this basic coverage.

The states would also purchase coverage for the costs of catastrophic illness expenses for the medically indigent. There would be no federal reimbursement for this state coverage.

Part B (Catastrophic Coverage) would have the secretary of HEW establish a program of insurance against the costs of catastrophic illness. Any U.S. resident whose income is above the level of medical indigence would be entitled to reimbursement for expenses incurred as a result of catastrophic illness. Federal reimbursement would be 90 per cent of total eligible expenses.

Eligible expenses would be those health care costs above whichever of the following is the larger: (a) \$1,000 for those 65 or \$5,000 in any other case, or (b) 25 per cent of the gross income of the individual or his family.

Funds Management

Funds for this two-part program would be managed by a Federal Health Care Trust Fund. Money for this trust fund would be raised through a 0.4 per cent tax on wages and self-employment income, and on other income in excess of \$2,000 up to the maximum income in use for purposes of the social security tax. There would also be a 0.4 per cent employer tax.

Hall estimates that the Part A would cost the federal government about \$3.7 billion a year. The cost to the states for Part A would be about \$600,000. Medicaid presently costs the states about \$2.5 billion.

There was no estimate as to the cost of Part B, but Hall said that it would be only a small fraction of the cost of a comprehensive national health insurance program of the type being pushed by organized labor.

"All government efforts to date have been directed at providing first-dollar coverage," Hall said. "Invariably, first-dollar coverage entails high administrative costs, for it requires that many small claims be processed. Thereby the substance of the program is eroded. My aim is to amend and to protect existing law or substitute thereof so that the public can be insulated from disastrously high costs; give meaningful relief to those hardest hit by extensive medical expenses, make the existing program work easier and at the same time make the greatest use possible of the dollars available."

Congressional Approval

Congress, in the final days of the 91st Congress, approved two important medical bills dealing with family practice and birth control.

The main feature of the family practice legislation authorized a three-year, \$225 million program to help

medical schools establish and operate departments to train family physicians.

The legislation passed the Senate and House with virtually no opposition. It was supported by the American Academy of General Practice and the American Medical Association. The Nixon Administration opposed it, mainly because of its categorical grant character.

Only nine U.S. medical schools already have established departments of family practice, and chief sponsors of the legislation hailed its passage as an important step toward alleviating the shortage of family physicians and slowing down the trend to specialization in the practice of medicine. It was praised as "a significant step in the efforts of Congress to meet the health crisis facing this nation."

Birth Control

A family planning bill authorizes birth control services, except abortion, for all American women who cannot afford them. The birth control services will include contraceptive drugs and devices, as well as consultations, examinations, and instruction.

The legislation also provides for federal aid for birth control research and establishes an Office of Population Affairs in the Department of Health, Education and Welfare.

To finance the program for the first three years, House-Senate conferees agreed on a compromise authorization of \$387 million. The House had approved \$267 million for three years and the Senate, \$967 million for five years.

Expenditure of federal funds for abortion is prohibited.

GEORGIA'S FAMILY PHYSICIANS HOLD 22ND ANNUAL SCIENTIFIC ASSEMBLY

The Georgia Academy of General Practice held its 22nd Annual Scientific Assembly in Augusta on November 11-14, and was one of the most enthusiastically attended meetings of the Academy in several years.

Drawing heavily on the faculty of the Medical College of Georgia, Family Physicians from throughout Georgia heard two full days of scientific lectures on penicillin and antibiotic therapy, emotional stress, allergy, obesity, acute respiratory failure, peripheral arterial disease, office radiology, hypertension, fractures and dislocations, and psychoneurotic anxiety and depression. In addition to seven guest lecturers from MCG, the Assembly's faculty included three out-of-state guest speakers. Each of the 10 speakers concluded his presentation with a lively and responsive question and answer session.

The second annual meeting of the GAGP Congress of Delegates was held in conjunction with the Annual Session. The Congress, complete with reference committees, and formalized by adherence to accepted parliamentary procedure, is the top policy making body of the Academy.

R. D. Walter Installed As President

Highlighting the traditional President's Banquet, Dr. R. D. Walter of Calhoun, was installed as the 1970-71 President of the Georgia Academy of General Practice. Dr. T. A. Sappington of Thomaston, outgoing President, did the honors with the symbolic passing of the gavel.

Other officers elected and/or installed were as follows: President-Elect George Mixon, Ocilla, Vice President Ollie McGahee, Jesup and Secretary-Treasurer Lyle Herrmann, Hapeville. Elected as members of the Board of Directors were as follows: A. J. Yates, Jr., Soperton; Gordon Davis, Sylvester; Norman Gardner, Thomaston and Loyd Yeargin, Dalton. The Congress of Delegates elected as Speaker and Vice Speaker respectively, Drs. James C. Dismuke of Adel and Wells Riley of Jonesboro.

Dr. Sappington was elected Chairman of the Academy's Board of Directors for the ensuing year.

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Clinical assessment of an individual's behavior pattern not only helps to define coronary-proneness per se, but also significantly enhances the predictive specificity of other more widely used risk factors.

Assessing the Risk Associated With Behavior Patterns

RAY H. ROSENMAN, M.D.,* *San Francisco, Calif.*

EPIDEMIOLOGICAL STUDIES have confirmed that coronary morbidity is significantly higher in Western societies characterized among other things by plethoric diets, higher serum lipids and relative physical inactivity, compared to less privileged groups. They also have confirmed that in such societies the rate of coronary heart disease (CHD) is significantly increased in groups of men who variously exhibit the well-known risk factors. On the other hand, the recent decades witnessing the coronary epidemic have not been characterized by parallel increases of dietary fats or of serum lipid levels. It is also entirely unclear why clinical coronary morbidity was so astonishingly low in earlier decades of this and in other centuries in the host of individuals who similarly ingested an habitually enriched diet and also indulged in little physical activity. Moreover, despite the probable pathogenetic role of dietary excess and physical indolence, as a group, the individuals who have been victimized have not been found to differ in dietary and exercise habits from the men who remain free of clinical disease during the course of prospective studies. The increased morbidity has occurred too rapidly to incriminate altered genetic factors.

Epidemiological studies have focused attention on the so-called risk factors under discussion in this Symposium. However, in an average population of middle-aged men, the clinically healthy individuals at risk with such adverse attributes, alone and in combination, are in the minority. Thus, for example (see Table 1), elevated serum lipids are present in only 20 to 30 per cent, diastolic hypertension in less

than 10 per cent, and various combinations of adverse characteristics in still lesser frequency.

These are typical findings, in this instance being derived from the Western Collaborative Group Study. This is an ongoing prospective study of CHD that was initiated in 1960 in a large cohort of 39 to 59 year old men who were employed in 10 participating California companies. Clinical CHD has been observed in 195 of 3,182 initially "healthy" men during the first mean six and one half year period of follow-up. For the present purposes the subjects of the two intake age decades have been combined into a single group and the findings are based on the data obtained at intake.*

Rates of CHD

The rates of CHD in groups of men exhibiting enhanced levels of various risk factors are significantly higher than in groups of individuals who are more favorably endowed (see Table 2). However, it can be seen that most men at risk with such adverse characteristics still remain free of clinical disease over the passage of time. Conversely (see Table 3), many victims of CHD are not prospectively characterized by these traditional adverse attributes. It seems clear that epidemiological studies have identified various characteristics that help to define coronary-proneness of *groups* of men but are far less specific for any given *individual*. This can be exemplified in a cohort of healthy 40 to 50 year old men. Serum cholesterol levels exceeding 260 mg/100 ml would prospectively characterize only 40 per cent of the potential coronary subjects. The remaining

* Presented at the Georgia Symposium on Prevention in Cardiology, Grady Memorial Hospital, Atlanta, Ga., May 28-29, 1969.

* The fasting triglycerides were initially obtained during the first annual follow-up examination in 1962. The figures for parental CHD history include history at intake and during the follow-up period.

TABLE 1
PROSPECTIVE HIGH RISK FACTORS AND INCIDENCE OF CHD

Risk Factor	Subjects at Risk		CHD Cases (6½ Yr.)		Type A Subjects		Type B Subjects		Annual Incidence of CHD (No./1,000 Men at Risk)			
	No.	% of Total	No.	% of Total	No. at Risk	No. CHD	No. at Risk	No. CHD	All Subjects	Type A	Type B	Significance †
All Subjects	3182	100.0	195	100.0	1584	139	1598	56	9.4	13.5	5.4	.001
Cigarettes 16+ /day	1183	37.4	108	55.4	643	78	540	30	14.0	18.7	8.5	.01
B/A LP Ratio 2.36+	989	31.4	88	45.4	526	61	463	27	13.7	17.8	9.0	.01
Triglycerides 177+	706	23.5	63	34.8	358	45	348	18	13.7	19.3	8.0	.01
Cholesterol 260+	642	20.4	77	39.4	354	54	288	23	18.5	23.5	12.3	.01
Parental CHD + History	623	19.5	53	27.2	338	35	285	18	13.1	15.8	9.7	—
*Chol. 225+, Tglyc. 148+, B/A 2.04+	467	15.6	55	30.4	261	35	206	20	18.1	20.6	14.9	—
Tglyc. 177+, B/A 2.36+	381	12.7	43	23.8	201	30	180	13	17.4	23.0	11.1	.05
Chol. 260+, B/A 2.36+	370	11.8	49	25.2	219	34	151	15	20.4	23.9	15.3	—
Diast. Blood Pressure 95+	293	9.3	34	17.4	171	29	122	5	17.9	26.1	6.3	.01
Chol. 260+, Cigs. 16+	289	9.2	43	22.1	167	30	122	13	22.9	27.6	16.4	—
Chol. 260+, Tglyc. 177+	253	8.4	32	17.6	137	24	116	8	19.5	26.9	10.6	.05
Chol. 260+, Tglyc. 177+, B/A 2.36+	168	5.6	25	13.8	99	19	69	6	22.9	29.5	13.4	—
Chol. 260+, Diast. BP 95+	77	2.4	15	7.7	49	14	25	1	31.2	44.0	6.2	.05
Chol. 260+, Cigs. 16+, DBP 95+ ..	33	1.0	7	3.6	22	7	11	0	32.6	48.9	0	—

* Mean lipid levels for total population.

† P values are based on chi square test with correction for continuity (Yates).

potential victims would be false negatives since they exhibited lower cholesterol levels. During a 10 year interval following initial observation, the suspect cholesterol high risk population would have been eight to 10 times greater than the morbidity. Moreover, the employment of the serum cholesterol as a predictive factor weakens after the age of 50 years and the use of other single attributes or combinations of risk factors show even less predictive specificity.

The intake studies of the participants in the Western Collaborative Group Study included determination of the behavior pattern by means of a specially structured psychological interview found to have a substantially high degree of inter-rater agreement. Subjects were classified as exhibiting the Type A Behavior Pattern if they exhibited enhanced traits of aggressiveness, ambitiousness and competitive drive, preoccupation with deadlines and an habitual strong sense of time urgency, and if they exhibited various motor stylistics associated with such an emotional interplay. Subjects without most of these behavioral characteristics were classified as exhibiting the converse Type B Behavior Pattern.

Clinical CHD

Clinical CHD occurred in 195 of the 3,182 initially healthy men who were observed during a mean

six and one half year period of follow-up, an annual incidence of 9.4 per 1,000 men at risk. Clinical CHD was observed in 139 of 1,584 men at risk with the Type A Behavior Pattern, an annual rate of 13.5 per 1,000 men, compared to 56 of 1,598 Type B men, an annual rate of 5.4. The difference in these coronary morbidity rates was highly significant.

If the relationship of Pattern A were merely an artifact of its association with some other risk factor, then stratifying by values of that risk factor should reduce the association of Pattern A with the coronary incidence to negligible levels. However, the higher incidence of clinical disease in Type A compared to Type B men was found to prevail when stratified by high or low levels of each other risk factor (see Tables 1-3). Indeed, it can be seen that in many instances the coronary rate of Pattern A men with a *low* level of some other risk factor approximated the rate observed in Pattern B men with a *high* level of the respective other characteristic. Among individuals with low levels of various risk factors (see Table 3), a significant incidence of CHD still was observed in Pattern A men, invariably higher than the very low morbidity observed in Pattern B men with respective similar characteristics. The mean lipid levels in each subgroup shown in the tables were determined and showed only insignificant

TABLE 2
INCIDENCE OF CHD FOR VARIOUS SUBJECTS

Risk Factor	Total	No. at Risk		No. of CHD (6½ Yr.)			Annual Incidence of CHD (No./1,000 Men at Risk)			Signifi- cance†
		Type A	Type B	Total	Type A	Type B	Total	Type A	Type B	
All subjects	3182	1584	1598	195	139	56	9.4	13.5	5.4	.001
Cigarettes										
0	1651	781	870	72	53	19	6.7	10.4	3.4	.01
16+	1183	643	540	108	78	30	14.0	18.7	8.5	.01
Parental CHD										
History -	2536	1248	1288	142	104	38	8.6	12.8	4.5	.01
History +	623	338	285	53	35	18	13.1	15.8	9.7	NS
Diastolic Blood Pressure										
94-	2866	1415	1451	161	110	51	8.6	12.0	5.4	.01
95+	293	171	122	34	29	5	17.9	26.1	6.3	.01
Cholesterol										
224-*	1619	778	841	53	37	16	5.0	7.3	2.9	.01
260+	642	354	288	77	54	23	18.5	23.5	12.3	.01
Triglycerides										
99-	851	403	448	28	20	8	5.1	7.6	2.7	.01
177+	706	358	348	63	45	18	13.7	19.3	8.0	.01
Beta/Alpha LP ratio										
2.03-*	1815	892	923	81	62	19	6.9	10.7	3.2	.01
2.36+	989	526	463	88	61	27	13.7	17.8	9.0	.01

* Mean lipid levels for total population.

† P values are based on chi square test with correction for continuity (Yates).

TABLE 3
PROSPECTIVE LOW RISK FACTORS AND INCIDENCE OF CHD

Risk Factor	Subjects at Risk		CHD Cases (6½ Yr.)		Type A Subjects		Type B Subjects		Annual Incidence of CHD (No./1,000 Men at Risk)			
	No.	% of Total	No.	% of Total	No. at Risk	No. CHD	No. at Risk	No. CHD	All Subjects	Type A	Type B	Signifi- cance†
All subjects	3182	100.0	195	100.0	1584	139	1598	56	9.4	13.5	5.4	.001
Cigarettes: None	1651	52.3	72	36.9	781	53	870	19	6.7	10.4	3.4	.01
Parental CHD: Negative history ..	2536	80.3	142	72.8	1248	104	1288	38	8.6	12.8	4.5	.01
*Cholesterol 224-	1619	51.5	53	27.2	778	37	841	16	5.0	7.3	2.9	.01
Triglycerides 99-	851	28.3	28	15.5	403	20	448	8	5.1	7.6	2.7	.01
*B/A LP ratio 2.03-	1815	57.3	81	41.8	892	62	923	19	6.9	10.7	3.2	.01
Diastolic Blood Pressure 94-	2866	90.7	161	82.6	1415	110	1451	51	8.6	12.0	5.4	.01
Chol. 259-, DBP 94-	2298	72.8	99	50.8	1110	70	1188	29	6.6	9.7	3.8	.01
*Chol. 224-, Cigs. 0	928	29.5	22	11.3	411	15	517	7	3.7	5.6	2.1	.05
Chol. 259-, Cigs. 0, DBP 94-	1223	38.9	37	19.0	554	27	669	10	4.7	7.5	2.3	.01
Chol. 259-, Tglyc. 176-, B/A 2.35- ..	1557	51.9	61	33.7	750	44	807	17	6.0	9.0	3.2	.01
*Chol. 224-, Tglyc. 147-, B/A 2.03- ..	917	30.6	26	14.4	446	20	471	6	4.4	6.9	2.0	.01
*Chol. 224-, Tglyc. 147-, B/A 2.03-, Cigs. 0, DBP 94-	497	16.5	12	6.6	218	8	279	4	3.7	5.7	2.2	—

* Mean lipid levels for total population.

† P values are based on chi square test with correction for continuity (Yates).

differences in the respective groups of Type A and B men.

Summary

The results of these studies indicate that the behavior pattern of an individual is significantly and in part independently related to his prospective coronary status. Accordingly, clinical assessment of an individual's behavior pattern not only helps to define

coronary-proneness per se but significantly enhances the predictive specificity of other more widely used risk factors. Quinlan, Barrow and their associates, and elsewhere Caffrey, have recently presented some of the results of their studies in large groups of Benedictine and Trappist monks. The behavior pattern of their population also was determined with the use of the same interview developed in our laboratory.

They found that the prevalence of angina pectoris was over twice as high and the prevalence of previous myocardial infarction over four times as great in the monks classified as Type A men than in those classified as Type B individuals. It is also of interest that in 1966, Brozek, Keys and Blackburn reported results of psychological investigations done in the course of their longitudinal study of CHD. The potential candidates for CHD compared to the men who remained clinically normal during 14 years of follow-up were found to exhibit a higher activity drive, were more "masculine" in their interests, were

more likely to be "on the go" and to "speak, walk, write, drive, work and eat fast, even when he does not have to do so," a rather good description of the Type A individual. The differences between the coronary candidates and the control group were found to be significant at the 5 per cent level. These two references are cited since they present factual data rather than opinion. Both studies confirm the value of assessing the behavior pattern in the total assessment of an individual's candidacy for future clinical CHD.

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This study was supported by the National Institutes of Health, Research Grant HE-03429, and the Irwin Strasburger Memorial Medical Foundation of New York.

PROFESSIONAL IDEALS*

Recently, many letters have been received by the Judicial Council complaining of an apparent preoccupation by an increasing number of physicians with the financial aspects of their medical practice.

The Judicial Council reaffirms that the laborer is worthy of his hire and the physician is entitled to reasonable compensation for the service he performs. At the same time, the Council must point out that the "prime object of the medical profession is to serve humanity; reward or financial gain is a subordinate consideration."

In 1934, the House of Delegates said "one of the strongest holds of the profession on public approbation and support has been the age old professional ideal of medical service to all, whether able to pay or not." The Council believes it would be helpful if the House were to reaffirm that policy at this meeting.

Some physicians seem to believe that the practices of business enterprises should be utilized by physicians in order to "encourage prompt attention to medical accounts." They ask, "Why shouldn't we be paid as soon as the dry goods store, the grocer, or the TV service man?"

Ideally, the physician should be paid promptly. If the physician is not paid as promptly as other creditors he should recall that he is a professional man with all the perquisites that that term implies. Our patients in large number carry insurance to cover the cost of medical services. (They do not insure payment of the cost of other professional or business services to any notable extent.) Governmental programs have been instituted and are being developed continually to provide payment for medical care to those who are unable to provide this payment.

If the profession were to cast aside its ideals and

traditions and adopt the practices of business, trade or industry in dealing with patients, then the profession would be casting aside also the perquisites that have been accorded it. The increase of collections by adding 1½ per cent interest per month to a bill of an honest patient embarrassed because of inflationary trends, or the bill of some retired person living on a small pension is, in the opinion of the Judicial Council, not justifiable. It simply is not worth it from any point of view. The imposition of a penalty on the bill of a "deadbeat" is not likely to cause him suddenly to change; the chances are that he will become even less likely to pay.

A physician who demands a satisfactory credit report on an individual before accepting that individual as a patient is demonstrating that to him financial compensation is the prime object and reward of his profession.

A physician who publicly refuses to see a patient, who had an appointment, because patient's balance on account was "too high" is demonstrating that he respects neither himself nor his profession.

These examples are real. The Council believes they are the exception and they seem more conspicuous because of that fact. Nonetheless, these practices reflect adversely on the whole profession and especially on the countless physicians who extend credit willingly or write off old accounts because they are dedicated to serving mankind.

The Judicial Council therefore recommends that the House of Delegates reaffirm that the prime object of the medical profession is to render service to humanity; financial gain is a subordinate consideration.

The Council recommends that the House call this reaffirmation of policy to the attention of constituents and component medical societies, asking them to urge all physicians to adhere faithfully to the professional ideals, traditions and goals of American medicine.

* A report from the Judicial Council of AMA, adopted by the AMA House of Delegates, December 1, 1970.

Multiple Risk Factors and the Prediction of Coronary Heart Disease

FREDERICK H. EPSTEIN, M.D.,* *Ann Arbor, Mich.*

THIS PRESENTATION is concerned with prediction of coronary heart disease in terms of multiple risk factors. The terms "prediction" and "risk" are really interchangeable and one could equally well say, "The risk of coronary heart disease in terms of multiple predictive factors." Both terms express a probability. This is an important and relatively new word in medicine as a deliberate and quantitative, rather than an intuitive, concept. Not all those at risk will develop manifest disease, but the probability for some is greater than for others.

In this discussion, two kinds of probability will be used: *relative probability* or *relative risk*, which is usually called the morbidity ratio, and *absolute risk*, which is really nothing other than the incidence of new disease. In that sense, relative and absolute risks are, in fact, average probabilities of developing disease among persons harboring risk factors singly or in combination.

A third term is of importance: the frequency with which a risk factor or a constellation of such risk factors occurs in the population. A person with a very high level of one risk factor (say a cholesterol level of 500) or moderate elevations of four, five or more risk factors may have an absolute and relative probability of developing disease which is very great. However, such persons may be quite rare in the population and would not present, for lack of a better word, a "public health problem," however much they are in need of preventive action as individuals.

Matters for Concern

These, then, are matters of much practical concern. This point has just been made with regard to the population frequency of risk factor elevation. It is equally important to look at the practical implications of the terms relative and absolute probability of developing disease. The relative risk of death in

one group may be 10 times greater than in another, but if the absolute risks are, say, one in a million and one in a hundred thousand, respectively, even a person in the high risk group need not worry too much about his individual chances of dying.

In the case of coronary heart disease, of course, persons at excessive risk are not only very common in the general population, but the absolute risks are of a high order while the relative risks show steep gradients. It is the steepness of the gradients which is at the root of the belief that measures which would carry a person from a high to a low risk category in terms of predictive factors will have preventive value. This belief is based on the assumption that the association between a risk factor and the event of overt illness is largely causal in nature. Unfortunately, this belief is still predominantly based on circumstantial evidence, especially when one talks about risk factors in combination; hence, the need for preventive trials. However, the circumstantial evidence is so compelling that one's practical approach can justifiably be a matter of belief rather than mere faith.

It stands to reason that the risk of coronary disease bears some relation to the number of risk factors which are being harbored. One would expect that a man with an elevated serum cholesterol level will be worse off if he also smokes, and that the chances of developing a heart attack will increase further when blood pressure is raised, especially if such a person is also physically inactive and obese.

Before proceeding further, it must be stated that reasonably reliable estimates are not available for risk factor combinations in excess of two or, at best, three selected variables. These will be presented and do, indeed, suggest that risk factors have a cumulative effect on the incidence of coronary disease. However, there is at present no way to tell from the evidence whether the effects are simply additive or act in some complex, synergistic fashion. The latter is more likely and it is also likely that the degree of

* Presented at the Georgia Symposium on Prevention in Cardiology, Grady Memorial Hospital, Atlanta, Ga., May 28-29, 1969.

synergism will vary according to the specific risk factor combinations which are involved.

Consider Interaction

One must consider not only the interaction between risk factors and coronary disease but the interaction between the risk factors themselves. In the most simple situation where a number of risk factors lack any correlation, two points can be made: (1) Elevation of each risk factor level is likely to have different and independent causes; this is largely the case for serum cholesterol and blood pressure levels. (2) From knowledge of the population frequency of the single factors, one can calculate the population frequency of their various combinations.

It must be obvious that by the laws of chance, a physician engaged in preventive risk factor detection in his practice or an evaluator of tests from a screening program will be less likely to see persons who are high on all of four risk factors than those high on, say, only one or two.

Let us assume that there are three non-correlated risk factors, each with a population frequency of 15 per cent; that is, 15 per cent of the population have elevated levels; then only a little more than three persons in a thousand will be high on all three.

When risk factors are correlated, as they often are (for example: blood pressure and blood sugar level), high levels will co-exist even less often. Moreover, the higher the correlation between any two factors, the more likely it will be that they have a common, underlying cause (for example: elevated blood pressure and obesity) and, by measuring one factor in a risk factor detection program, one also measures partly the other (for example: serum cholesterol and triglyceride). All these are matters of not only academic but highly practical importance.

From what has been said, one should not be distressed that there are currently no solid coronary heart disease prediction estimates for risk factor combinations above two or three variables because higher combinations are not only relatively infrequent in the population but their predictive power may possibly not *greatly* exceed what can be achieved in terms of two or three variables.

Multiple Risks

The most simple and also most probably the most powerful currently known multiple risk factor combination involves serum cholesterol and blood pressure. The data have been available for quite a long time, especially from the Framingham study but, somehow, their practical significance has never been widely recognized in the form which is particularly

useful. In this form, individuals are characterized according to whether they show elevation of one or both of these variables. By measuring these two factors, a simple and cheap procedure, two-thirds of all subsequent events of coronary disease can be identified among those at preferential risk. No less than about 30-40 per cent of middle-aged men have cholesterol and blood pressure levels in a range where their risk of developing overt coronary disease in the next 10 years is one in five, twice as high as among their companions whose levels are below the cutting point chosen.

For the purpose of screening programs, it is customary to set more or less arbitrary so-called "cutting points" or "screening levels" to define "abnormal" values. Since the risk factors themselves and the risk associated with them are generally continuous variables, there is no point where normality ends and abnormality begins. This, in a sense, is also a matter of probability since, the higher the level, the more likely it is to be abnormal. Furthermore, single cutting points are undesirable from the point of view of inferring causality between a risk factor and the disease because an association is more likely to be causal if there is, as it were, a dose-response relationship so that step-wise increases in level result in corresponding increases in risk. Unfortunately, from a practical point of view, single cutting points which divide risk factors into two levels, elevated and not elevated, are the only practical approach, short of multivariate analyses, if more than two or, at the very most, three risk factors are evaluated simultaneously.

This is illustrated by considering various combinations of three risk factors; serum cholesterol, systolic blood pressure, and cigarette smoking levels. If one divided the levels into low, medium and high, instead of just two (high and not-high), there would be 27 instead of the eight combinations which are presented in the diagram, which would result in a display of unmanageable complexity.

The data to be discussed are not based on any particular study but reflect a reasonably informed digest from a number of prospective epidemiological investigations.

There is a total of 100 men among whom 14 new events of coronary heart disease develop in a 10 year period. Only 20 per cent of the men are at low risk, as defined (i.e., in the lower two-thirds of the distribution of the three risk factors considered). The probability for such a man to develop heart disease in 10 years is only 5 per cent, still an appreciable risk. On the extreme other end of the scale, this risk is as high as 30 per cent, but only 5 per cent of the population are in this category. The balance of numbers is such that only 1.5 of the total 14 new

events over a 10 year period among the 100 men develop in this highest risk category.

Risk Exposure Rates

It should be noted that half of the 100 men are exposed to a risk of 15-20 per cent. Among these men it can be predicted that between about one in seven and one in five, coronary disease will become manifest in the next 10 years. There are nine such men out of the 14. Six of them will develop myocardial infarction; the rest, angina pectoris. Of the six, two will die within a month of onset of attack, and half of the latter will die before reaching the hospital and, thus, beyond reach of coronary care units.

About 10 of the total 14 new events will be heart attacks, and one of the 10 will die suddenly from the first attack. Of course, over a 10 year period, a considerable number of the survivors from the first attack will die, suddenly or otherwise, from a recurrent attack.

All this may not sound too discouraging as far as survivorship is concerned, but it must be remembered that, among men of this country alone, not counting women, 300,000 die each year of coronary disease, and at least a third of them will die suddenly. A third of all deaths, sudden or otherwise, occur among men below age 65. The need for prevention is clear.

Project Results

Before moving further, a few brief remarks on two risk factor combinations, but using two instead of a single cutting point, should be made so that three levels—low, medium and high—are created. Such data are available from a project including about 10,000 men, comprising the pooled experience from the six epidemiological studies of coronary heart disease in the United States with the longest follow-up experience; that is, those in Framingham, Albany, the Gas Company Study in Chicago, the Western Electric Study in Chicago, and civil servants study in Los Angeles, and the study initiated by Keys, earlier than any of the others, in Minneapolis.

Some of the preliminary results were presented by Professor Felix E. Moore at the American Heart Association Cardiovascular Epidemiology Conference in New Orleans last March, but they have not been released for publication. Analyzed in terms of the three risk factors, serum cholesterol, blood pressure and smoking in the various two-by-two combinations, there is an orderly and step-wise increase in the risk of myocardial infarction for each of these three factors singly as one moves from low to medium and high levels, defined by the tertiles of distribution. Taking the cholesterol-smoking combination,

the risk is almost five times higher when men high on both are compared with men low on both. For cholesterol and diastolic blood pressure, the corresponding figure is almost six-fold.

Gradients of this general type have been reported by the individual studies before, but the pooled experience is based on a very large number of person-years of experience. It is inferred that these gradients, being in the nature of a "dose-response" relationship, have causal significance and that three-way splits into low, medium and high levels yield remarkably steep gradients in risk for any combination of two risk factors.

Multiple Causes

For the past 10 or 15 years there has been general acceptance of the view that both the underlying lesion, atherosclerosis, and its clinical consequences have multiple causes. Even at the cellular level, it is unlikely that only a single pathogenetic mechanism is involved. A major obstacle to the orderly and systematic dissection of these multiple and often interacting influences has been the unavailability of suitable statistical techniques to take simultaneous account of the predisposing factors and causes and to relate them to the endpoint of disease.

The history of the application of discriminant function and other types of multivariate analysis has been briefly reviewed elsewhere. Two of the most recent examples may be quoted. In their study of London transport workers, Morris and his associates have used the traditional form of discriminant function analysis to derive a score which will predict the probability of future disease according to the array of antecedent measurements. When these scores were divided into four equal parts (quartiles), those in the highest quartile are about eight times more likely to develop overt disease than those in the lowest quartile of risk. In a 10 year period, those in the highest quartile stand about one chance in three to develop manifest disease. It is of great interest that serum cholesterol and blood pressure alone are almost as predictive as the whole array of nine factors. The reason must be that either the correlation between blood pressure, cholesterol and the other variables is high so that they are merely another way of measuring cholesterol and blood pressure, or that they have little predictive value in their own right.

Very similar data come from the Framingham study based on Cornfield's multiple logistic function. The development of this multiple logistic function has marked a distinct advance toward the solution of these multivariate problems. The method takes into account interactions between the variables and the so-called beta coefficients provide a measure of the relative importance of each factor in contributing

to the predictive power of the total score. When total scores for the Framingham population of men are divided into 10 equal deciles, there is a dramatic 30-fold gradient of risk between the highest and the lowest decile.

The practical usefulness of these scores in identifying high-risk individuals on a quantitative scale is obvious. The potential value of this method in assessing the relative contribution of each factor toward the total risk is equally apparent.

Matrix of Interactions

Finally, in the process of calculating the beta-coefficients, a matrix of interactions has to be constructed which provides a possible index of etiologically significant causes shared by any interacting variables. In our own data from the Tecumseh study, for example, there is a suggestion that the risk of thin hypertensives toward coronary disease is greater than that of their more obese counterparts. This suggests, perhaps, that the hypertension associated with, and possibly caused in part by, obesity is more benign than a form with a stronger genetic and a weaker environmental component. These are merely speculations, but they show the potential application of these multivariate techniques in the generation of new hypotheses through more detailed scanning and penetrating analysis of the data.

Cornfield's multiple logistic function has recently also been used in identifying high-risk individuals to be invited as participants in a controlled anti-smoking clinical trial presently conducted among British civil servants by Reid and Rose.

There is much need to "plug," so to speak, into these predictive functions physiologic variables and environmental factors which have not yet been incorporated into them. It would be the hope that the inclusion of additional predictors would make the scores both more sensitive and specific, and concentrate among a smaller segment of the population a larger number of the future disease candidates.

In this connection, one thinks particularly of triglycerides and glucose tolerance, taking into account their interactions, level of physical activity, eating habits and patterns, family history, and some index of psychosocial stress. It is admittedly open to question whether the inclusion of a greater number of variables will, indeed, increase sensitivity and specificity of the score or would, in fact, dilute the predictiveness of the score. In the latter case, the usefulness of the approach would not be by any means undermined or negated. On the contrary, in such an event, the application of scores derived from multiple logistic functions would still be helpful in defin-

ing not one but several distinct subgroups of the population which would be at preferential risk in terms of different but discreet constellations of risk patterns. Actually, this would be the more likely outcome.

Screening Process

In practice, screening programs identify individuals who are at increased risk on account of various single or combined risk factors, differing from person to person so that there is no universal approach to the preventive treatment of all those who come out positive on the test. Thus, even though the screening process is an assembly-line, mass-produced operation, management of the abnormalities detected is not. Nevertheless, some type of group therapy, to borrow a term from another discipline, will be needed to cope with the large number of persons at increased risk. The distressingly small proportion of low-risk individuals in the American population has already been pointed out. Screening in terms of multiple risk factors becomes, therefore, not so much an operation to find a small number of susceptibles who include the majority of persons at risk but to identify, among the large group of susceptibles, the specific factors among the whole array of potential ones which require preventive therapy in individual members of the general population.

The multiplicity of risk factors and detrimental, environmentally-induced influences has another consequence from the public health point of view: the need for an effort on a national scale to alter the multiple detrimental ingredients of the environment in such a way that the overall population exposure to them is decreased. Therefore, multiple risk factor detection programs and individual or group therapy of persons at increased risk, in conjunction with community-wide action programs to affect environmental changes, are integral and essential parts of a total coronary heart disease prevention effort.

*University of Michigan
School of Public Health 48104*

Spring Meeting

GEORGIA RHEUMATISM SOCIETY

1:30 p.m., March 26, 1971

**Georgia Mental Health Institute
1256 Briarcliff Road
Atlanta, Georgia 30306**

Obstetrical Delivery After Jejunio-Ileostomy for Obesity

CHARLES E. WILLS, JR., M.D., *Washington*

ONLY A HANDFUL of papers have been published on the surgical by-pass for obesity, and almost nothing has been published concerning pregnancy following the surgical bypass. Dr. Payne¹ reported one case in which three normal pregnancies followed the jejunio-ileostomy. This patient's by-pass consisted of 15 inches of jejunum, and 20 inches of terminal ileum. Dr. Barron² described three patients who had successful pregnancies after the by-pass. The author³ reported two cases. But despite these reports, there has been no detailed description of these cases.

The purpose of this paper is to report six cases of obstetrical delivery following the jejunio-ileostomy. These cases occurred during the follow-up of 139 women who had the surgical by-pass between November, 1963, and July, 1970.

Description of Surgery

All six cases had a jejunio-ileostomy. The jejunum was divided 14 or 15 inches below the ligament of Treitz, and anastomosed, end-to-side, into the terminal ileum, either 10, eight, or four inches above the ileocecal junction. The distal end of the jejunum was closed and left as a blind pouch. (See Table I.)

TABLE I—MEASUREMENTS OF BY-PASS			
Case	Jejunum Inches	Ileum Inches	Revised Inches
1	15	10	
2	15	8	14-4
3	14	4	
4	14	4	
5	14	4	
6	14	4	

Case Report

1. Twenty-two-year-old white female, 63 inches in height, and weighing 227 pounds. This patient was seen in February, 1966. She had a history of two years of sterility in marriage, and three months

of menorrhagia and metrorrhagia. She had been overweight since the age of nine. Since the age of 10, she had tried many diets and pills, including thyroid tablets for obesity, with no success. Her mother was obese, but her father and five sisters were of normal weight. On February 2, 1966, a surgical by-pass was performed, anastomosing 15 inches of the jejunum to the terminal ileum, 10 inches above the ileocecal junction. A dilatation and curettage was done at the same time, with a pathological diagnosis of cystic glandular hyperplasia. Mild diarrhea followed the surgery, but, in a few months, levelled off at one-to-three bowel movements per day. She lost weight rapidly, and by November, 1967, her weight was 109 pounds.

Her menses were scanty and irregular, so in October and November of 1967, she took Norethindrone with Mestranol (Ortho-Novum contraceptive tablets, 1 mg.). This regulated the menses, and she stopped them after two months. In January, 1968, she developed acute pelvic inflammatory disease, which was treated with Sulfamethoxazole (Gantanol), and later with Tetracycline-Amphotericin-B (Mysteclin-F). She had a normal menstrual period starting January 1, 1968, and spotted only one day in February, when she became pregnant.

In May, 1968, a perirectal abscess developed and was drained surgically. She was hospitalized again in July, 1968, for recurrence of the perirectal abscess, and for potassium deficiency. By August, 1968, a rectal fistula developed from the perirectal abscess. In September, her hemoglobin was down to nine grams, and she was given 1,000 ml. of whole blood. The anemia was thought to be due mainly to bleeding from the perirectal abscess and fistula, rather than bleeding related to the by-pass. This is suggested by the author's experience with 171 by-passes; anemia does not result from the jejunio-ileostomy.

On October 8, 1968, after 24 hours of false labor, her membranes were ruptured, and labor was induced with Oxytocin synthetic (Pitocin). Three

hours later, a saddle spinal was done with six mg. of Tetracaine hydrochloride (Pontocane in 10 per cent dextrose). One hour later, she was delivered by outlet forceps and episiotomy. The male infant weighed five pounds, five ounces. Three days later, both mother and baby were discharged. In February, 1969, her rectal fistula was successfully repaired. In October, 1969, a small ventral hernia developed. Her weight in March, 1970 was 108 pounds.

2. Thirty-two-year-old white female, 64 inches in height, and weighing 270 pounds in June, 1966. Previously, this patient had had three full-term pregnancies and seven miscarriages. In 1961, she had mental illness, a suicide attempt, and electric shock therapy. Her blood pressure in 1966 was 145/115. On June 26, 1966, a jejunio-ileostomy was performed, using 15 inches of jejunum and eight inches of terminal ileum. In August, 1967, a uterogram was done to evaluate sterility, and only the right Fallopian tube appeared open. In September, 1967, her blood pressure was 120/80, and her weight was 210 pounds. She developed a deep femoral thrombosis; this subsided with antibiotics, anti-inflammatory, and anti-coagulant therapy. On August 26, 1968, she intussuscepted the blind jejunal loop, and, at laparotomy, it was manually reduced and plicated. A liver biopsy reported normal liver tissue. Her bypass was revised to 14 inches of jejunum and four inches of terminal ileum.

She became pregnant after menstruating on October 10, 1969. On March 21, 1970, her serum calcium was 3.3 mEq./100 ml. (normal—4.5 to 6.0 mEq./100 ml.) and serum potassium was 2.2 mEq./100 ml. (normal—3.5 to 5.1 mEq./100 ml.), and serum protein was 5.2 grams/100 ml. (normal—six to eight grams/100 ml.). This was treated with intravenous calcium and potassium. Her weight was down to 180 pounds. She had three additional admissions for treatment of hypocalcemia, hypokalemia, and hypoproteinemia, with leg edema. Her prenatal course was endured only by much complaining and unhappiness. Her expected date of confinement was July 19, 1969. On July 28, 1969, labor started, and she delivered spontaneously after 45 minutes of labor. Her anesthesia was saddle spinal. Her baby weighed five pounds, six ounces. Following delivery, the edema was eliminated with diuretics, and she weighed 155 pounds. A total hysterectomy was performed on April 9, 1970, for a fibromyoma with symptoms of menorrhagia and metrorrhagia. Surprisingly, a chronic intussusception of the blind loop of jejunum was found and resected. She was given 1,000 ml. of whole blood during the surgery.

3. Twenty-six-year-old white female, 65 inches

in height, and weighing 236 pounds. Her past history included two previous normal pregnancies, backache, dyspareunia, and uterine retroversion. Her blood sugar peaked at 187 mg./100 ml. during a glucose tolerance test. Her blood pressure was 150/100. On January 13, 1967, her uterus was suspended, and a jejunio-ileostomy anastomosing 14 inches of jejunum to four inches of the terminal ileum was performed. Her weight loss was disappointing. In January, 1968, she weighed 205 pounds. Her blood pressure was 130/80. Her blood sugar peaked at 110 mg./100 ml. during a glucose tolerance test. She was having two to three bowel movements per day. She became pregnant in February, 1968, with an expected date of confinement on December 2, 1968. No difficulties were encountered prenatally. Due to lack of reliable transportation and 50 miles distance from the hospital, on November 22, 1968, she was induced into labor by amniocentesis and Oxytocin synthetic (Pitocin). One hour later, she delivered spontaneously a male infant weighing four pounds, 15 ounces. Following this, she had no difficulties, and by February, 1970, her weight was up to 226 pounds. Due to dysmenorrhea, dyspareunia, pelvic pain, and backache, a total hysterectomy was performed. The jejunal segment from the ligament of Treitz to the jejunio-ileostomy site then measured 23 inches, where it had been 14 inches. The distance from the jejunio-ileostomy site to the ileocecal junction was nine inches, where it had been four inches. This may account for the disappointing weight loss. The jejunio-ileostomy was revised to again measure 14 inches of jejunum and four inches of terminal ileum. Since this time, her weight has fallen, with a recorded weight of 170 pounds in July, 1970.

Case of Miscarriage

4. Twenty-four-year-old white female, 63 inches in height, and weighing 179 pounds. This patient was para-2, gravida-2. She weighed 115 pounds until she divorced her husband in January, 1965. Following this, she progressively gained up to 179 pounds. There was a strong family history of obesity. On July 14, 1966, a jejunio-ileostomy was performed, anastomosing 14 inches of jejunum to four inches of terminal ileum. A year later, her weight was 145 pounds.

In July, 1968, she had a miscarriage. She became pregnant again, with an expected date of confinement of April 5, 1969. On March 9, 1969, a laparotomy was carried out, with a diagnosis of partial intestinal obstruction (performed in another city).⁴ On April 18, 1969, an intravenous pyelogram was done because of right flank pain, with the findings of hydronephrosis, greater than would be expected with a term pregnancy. For this reason, labor was

induced with Oxytocin synthetic (Pitocin), and she delivered spontaneously a five-pound, one-ounce male (in another city).⁵ The patient states that her first baby weighed eight pounds, and her second baby, five pounds, two ounces. Her weight after delivery was 118 pounds. In October, 1969, a hysterectomy was performed (in another city).⁶ By January, 1970, she was divorced again, and weighed 127 pounds. She states that she has episodes of abdominal pain thought to be intestinal obstruction. This patient is obviously emotionally unstable, and it is my opinion that she will continue to drift from one physician to another, and to complain enough to receive medical and surgical treatment of some kind indefinitely, whether or not she actually needs it.

5. Twenty-eight-year-old black female, 58 inches in height, and weighing 210 pounds, May, 1968. This patient gave a history of high blood pressure and cardiac enlargement since 1957. She had delivered her first two pregnancies normally. She had mild pre-eclampsia with her third pregnancy. Between her second and third pregnancies, a left salpingo-oophorectomy was performed, due to a twisted ovarian cyst. Preoperative study demonstrated a blood pressure of 140/90, non-specific T-wave changes on the electrocardiogram (inverted T-waves in all of the precordial leads), a mildly diabetic glucose tolerance test, and a reversed A-G ratio. At surgery on May 13, 1968, very dense adhesions involving the ileum were encountered. Due to this, this bowel was plicated, in addition to a jejuno-ileostomy using 14 inches of jejunum and four inches of terminal ileum. Two days postoperatively, she developed tachycardia and cardiac irregularity, which responded to digitalis. Postoperatively, she did well. In June, 1968, she became pregnant, with an expected date of confinement on March 8, 1969. Her blood pressure progressively increased during her prenatal period to 200/104 by her delivery date. There was no edema or proteinuria. On March 11, 1969, labor was induced by amniocentesis and Oxytocin synthetic (Syntocin) drip. During labor, the fetal heart tones slowed to 60, and a Caesarian section was carried out, with a diagnosis of placental insufficiency. A female infant weighing four pounds, 11 ounces was delivered (in another city).⁷ Her previous babies weighed five pounds, 13 ounces; five pounds, 12 ounces, and five pounds, 11 ounces, respectively. Her weight in April, 1969, was 120 pounds. In October, 1969, her weight was 117 pounds, and her blood pressure, 190/110. She was feeling well, having three bowel movements per day, and working regularly. She does not stay on any regular management for hypertension, in spite of advice to do so.

On January 16, 1970, an intestinal obstruction due to a band adhesion from the omentum to the left abdominal wall was encountered. Six feet of jejunum were resected, starting two feet below the blind jejunal pouch. The usual findings of abdominal distension, dilated loop of bowel, and vomiting did not occur. This is due to the blind end pouch, and makes the diagnosis of obstruction more difficult. A liver biopsy at this time demonstrated a normal liver. She quickly recovered from this surgery.

6. Nineteen-year-old white female, 65 inches in height, and weighing 209 pounds. This patient had one normal pregnancy five months previous to the by-pass. On July 13, 1967, a jejuno-ileostomy was carried out, using 14 inches of jejunum and four inches of terminal ileum. Following her surgery, she did well, but continued to have non-specific complaints of chronic fatigue and "bloated" abdomen. In July, 1968, her weight was recorded at 136 pounds. She was in early pregnancy with an expected date of confinement on March 23, 1969. Her prenatal course was uneventful. She delivered spontaneously on April 4, 1969, after a five-hour labor.⁸ Her female infant was normal, and weighed seven pounds, 14 ounces. In June, 1970, she weighed 139 pounds. She complained of an uncomfortable, gassy, full stomach. She stated that she was afraid to get pregnant again, because she had so much abdominal discomfort during pregnancy. She states that her pregnancy following the by-pass was much worse than her pregnancy preceding the by-pass. In July, 1970, her by-pass was taken down, and normal bowel continuity re-established.⁹

TABLE II—WEIGHT LOSS (in pounds)				
Case	Weight Before By-Pass	Weight After By-Pass	Total Weight Loss	Percentage Weight Loss
1	227	108	119	51
2	270	155	115	43
3	236	170	66	28
4	179	119	60	33
5	210	110	100	48
6	209	136	73	35

Metabolic Effects

1. Protein. The serum protein in cases one and three remained within normal ranges. Cases five and six each dropped slightly below normal levels on one occasion. Case four had only one postoperative test, recorded as 5.3 g./100 ml. Case two demonstrated five out of six postoperative tests to be below normal, with one test down to 4.8 g./100 ml. (normal—six to eight g./100 ml.). Case two has very inadequate eating habits, and had inadequate protein intake both before and after the by-pass.

TABLE III—WEIGHT OF INFANTS

Case	1st	Pregnancies Before By-Pass 2nd	3rd	Pregnancy After By-Pass
1				5 lbs., 5 oz.
2	7 lbs., 10 oz.	6 lbs., 8 oz.	7 lbs., 13 oz.	5 lbs., 6 oz.
3	6 lbs., 10 oz.	7 lbs., 7 oz.		4 lbs., 15 oz.
4	8 lbs.	5 lbs., 2 oz.		5 lbs., 1 oz.
5	5 lbs., 13 oz.	5 lbs., 12 oz.	5 lbs., 13 oz.	4 lbs., 11 oz.
6	8 lbs., 5 oz.			7 lbs., 11 oz.

2. Carbohydrates. Cases two and five had mildly positive diabetic glucose tolerance tests preoperatively.

3. Cholesterol. All cases had normal preoperative cholesterol levels. Postoperatively, levels dropped from 40 mg./100 ml. to 100 mg./100 ml.

Physiological Effects

1. Blood Pressure. Cases three and five had moderate hypertension preoperatively. Case three returned to normal blood pressure after weight loss. Case five did not improve.

2. Electrolytes. Cases one, two, and five had potassium deficiencies relieved with oral and intravenous replacement. Case two had calcium deficiencies relieved with oral and intravenous replacement.

Discussion

It appears that pregnancy can be recommended to women after the jejuno-ileostomy for obesity. More problems will be encountered than would be expected with normal women. The problems are no more than are seen with obesity and pregnancy, but

the problems may be different in nature. The obstetrician managing such a case should be thoroughly familiar with the problems encountered after the jejuno-ileostomy.

Summary

Six cases of pregnancy and delivery are presented, demonstrating that intestinal absorption after the jejuno-ileal by-pass is adequate for the nutrition of both baby and mother. With special considerations, these women can be advised to become pregnant.

Wills Memorial Hospital 30673

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COBB'S SYMPOSIUM '71 TO EYE SHIFT IN VALUES

A searching look will be focused on America's changing values this spring when five speakers from over the nation come to Georgia to lead Cobb County's Symposium '71.

Dr. Margaret Mead, eminent anthropologist, and Tom C. Clark, retired Associate Justice of the Supreme Court, will appear on the program, "America vs. America—The Revolution in Values."

Other speakers include Dr. Mark D. Altschule, faculty member of the Harvard School of Medicine and editor and publisher of *Medical Counterpoint* magazine; Dr. David Mathews, the 35-year-old President of the University of Alabama; and Dr. William Pinson, Jr., professor of Christian Ethics at Southwestern Baptist Theological Seminary in Fort Worth, Texas.

The sixth annual symposium will be held on the campus of Kennesaw Junior College in Marietta April

29-30. The event is co-sponsored by the Cobb County Medical Society Committee on Medicine, Religion and Law, the Cobb Judicial Circuit Bar Association, the Marietta-Smyrna Ministerial Association and Kennesaw Junior College.

Dr. Pinson will speak at the opening session Thursday evening, when the public is invited without charge. The other speakers, except Dr. Mead, will appear Friday morning and will participate in a panel discussion Friday afternoon. Dr. Mead will address the final dinner meeting Friday evening at the Regency Hyatt House in Atlanta.

Detailed information and registration blanks may be obtained from the Community Services Office at Kennesaw Junior College. Co-chairmen for Symposium '71 are the Rev. Earl Stallings and Dr. Charles R. Underwood.

Congress and the Health Care System

SENATOR HERMAN E. TALMADGE,* *Washington, D.C.*

I THANK YOU for the kind invitation extended to me to speak with you today on what we in Congress are doing that will have an effect on the health care system in the United States, and on the practice of medicine in particular.

As you know, I am a member of the Senate Finance Committee. It has responsibility for all Social Security legislation, including the Medicare and Medicaid programs. For over a year now, both the Finance Committee and the Committee on Ways and Means have been devoting long hours to a careful examination of these two important programs, and the part they play in the health care crisis that exists in the country today.

The House of Representatives passed a comprehensive bill reported by the Ways and Means Committee to amend the Social Security Act, particularly the Medicare and Medicaid programs. The Finance Committee considered the House bill and injected some ideas of our own. Then we moved to complete action on the bill in order to bring some of the changes that these two health programs need if they are to fulfill the promise of their enactment five years ago.

Complex Problems

The problems of Medicare and Medicaid are complex. Legislation dealing with them must be equally complex and extensive. I don't want to try to skim over all the provisions and all the problems. I couldn't possibly do justice to any of them. Instead, I would like to treat in some detail two of the most important issues confronting the programs, and two of the legislative proposals devised to deal with them.

The first proposal I will discuss came from the Ways and Means Committee. The second was initiated by the Finance Committee. The House established a limitation on federal participation for capital expenditures. You know there are few aspects of the health care system in the United States which

have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of health care facilities.

We have found, however, that the acceptance of the purposes of state and areawide health facility planning has not always been matched by meaningful action to achieve the end result of such planning. Thus, we have a situation under which a significant amount of federal funds is spent under the comprehensive health planning provisions of the Public Health Service Act to advance health facility planning at the state and local levels. At the same time, federal funds are extended for health services under Medicare, Medicaid, maternal and child health programs without full regard to whether health facilities providing these services are cooperating in such overall planning.

The Ways and Means Committee, and subsequently the full House of Representatives, saw a strong connection between sound health facility planning and the prudent use of capital funds. This must be recognized if any significant gains in controlling health costs are to be made.

Consistent Efforts

It is necessary to assure that Medicare, Medicaid and the maternal and child health programs are consistent with state and local health facility planning efforts. This is to avoid unnecessarily paying higher costs in the future where these costs result from duplication or irrational growth of health care facilities. Therefore, the House-passed bill included provisions for review of an institution's capital expenditures program. Any such expenditure which would change an institution's capacity, or which would substantially alter the kinds of services provided, should be examined to assure that such expenditures are consistent with the community's health resources needs.

We can no longer afford the expensive luxury of duplicating in a locale something that other facilities in the same locale can already provide. The provi-

* Presented at the Conference of State Medical Society Presidents, Sunday, November 29, 1970, Boston, Massachusetts.

sion simply sees to it that these Social Security health programs do not operate in a vacuum. It attempts to insure that they will be brought into the existing health planning process with respect to resource needs and priorities. Any vetoes of particular decisions would be made by the various local, area and statewide levels of planning agencies in existence. The Secretary would retain authority to overturn only a negative decision on the part of all the other echelons that have examined whether particular capital decisions are consistent with resource requirements. This provision affects hospitals and other health facilities more than it affects you or your constituents as practicing physicians.

Bennett Amendment

The proposal included by the Finance Committee will have a significant and, I hope, beneficial effect on your practice directly. One of the most interesting developments in medical legislation in recent years and one of the most promising for the future of health care, is the amendment to the Social Security Amendments of 1970 to establish Professional Standards Review Organizations to review the utilization of health care provided under the Medicare and Medicaid programs.

This amendment was proposed by Senator Wallace Bennett of Utah. The original idea was given to him in draft form by the American Medical Association. He broadened and strengthened the idea in his original amendment. Then the Finance Committee and Senator Bennett modified the proposal further after conferences with the Department of Health, Education, and Welfare, and other concerned organizations.

Hopefully, the Professional Standards Review Organizations—when fully operational—will provide the necessary mechanism, for the most part at the local level, to control and moderate the increasingly higher costs of Medicare and Medicaid.

We discussed this in depth in the Finance Committee. It was brought out that the federal government and its various public and private agents generally have been unable effectively to monitor and assure economical and efficient use of properly provided health care services in Medicare and Medicaid.

Senator Bennett said:

“What we must have are assurances that, in medicare and medicaid, only services necessary to proper health care are provided; that those services are provided on a basis consistent with professional standards; and that where medically appropriate, less

costly alternative modes and sites of health care are called to the attention of the attending physician.”

Present Controls

Under present Medicare and Medicaid law, some controls are provided to avoid payment of unneeded services. These include utilization review by physician staff committees in hospitals and extended care facilities of their own services. These existing review procedures have shown improvement over time. But they have not yet reached a satisfactory level of achievement. Furthermore, they have certain inherent defects, as you are aware. For instance, utilization review tends to suffer from conflict of interest. The present review procedures do not review the totality of services together—institutional and non-institutional. They are not based upon an adequate development of norms of care. They do not have sufficient professional participation.

Under Medicare, only institutional services are subject to utilization control. Utilization control of hospital services is primarily through medical staff committees. Essentially the same problems exist under Medicaid. We cannot place the blame on any particular person or group for these problems. We do not want to. The way Medicare and Medicaid are presently organized, we cannot have the efficiency we must have, if spiraling costs are not brought into line. It has become increasingly apparent that we must devise some new mechanism to do this. We on the Finance Committee feel strongly that the Professional Standards Review Organizations is that new mechanism. The Professional Standards Review Organizations would be established at local and state levels throughout the country. Each would include at least 300 practicing physicians. Each review organization would have basic responsibility for reviewing the health care services ordered and rendered by physicians.

In addition, each organization would make arrangements for the professional review of other types of health care. The P.S.R.O. will pay special attention to the medical necessity of the service. It would determine whether the care was provided in accordance with professional standards. The attending physician, where medically appropriate, would be encouraged to use less costly alternative sites and modes of treatment.

Cost Saving

Another important cost-saving feature involves pre-admission certification of medical necessity, where there is a possibility of over-utilization of services under the Medicare and Medicaid programs. As the amendment was originally proposed, the P.S.R.O. would have been required to establish

means of requiring and providing prior approval of all elective non-emergency institutional care and costly out-of-institution elective procedures and services. Such prior approval is certainly desirable. But the committee did not want doctors working in the new organization to be overburdened with prior approval workloads where potential overutilization is likely to be minimal.

For this reason, the Committee amended the proposal to permit the physicians to select the circumstances—such as certain diagnoses, or the admissions to certain institutions, or by certain practitioners—in which it might require and provide advance approval. In instances where prior approval of a hospital admission, for example, is required, but not provided, the physician would be free to admit his patient. But they and the institution would be on notice that the costs would not be paid by these programs.

Another significant feature is in the re-certification of need for continued institutional care. At present, as you know, this is done at the twelfth day under Medicare, regardless of the patient's age or illness. Under the amendment, professionally-determined norms of care directly related to the patient's age and illness would be applied in determining the point at which recertification should occur. For example, if a norm indicates that half the patients hospitalized for a specific operation are released in, say, eight days, then that would be the point at which the need for further hospitalization must be determined in order to assure payment by either Medicare or Medicaid of care beyond that point.

We were told in hearings that if the P.S.R.O.'s are effectively implemented throughout the country, they have the potential for moderating the costs of health care by as much as 20 per cent. This is, of course, a substantial savings. At present, the total annual costs of Medicare and Medicaid are approximately \$15 billion, and a reduction of 20 per cent would be considerable. Unquestionably this amendment to the Social Security Act can have a significant effect on the health care system in the United States. It will be most effective only if organized medicine takes the fullest possible part in its implementation and operation. You can have a tremendous influence in this regard.

P.S.R.O. Mechanism

This is why I welcomed this opportunity to speak with you. I hope you will bear with me as I relate in some detail just how the Professional Standards Review Organizations amendment will work. The Professional Standards Review Organizations mechanism would take effect along the following lines:

The Secretary of Health, Education, and Welfare,

after consultation with national and local health professions and agencies, would designate appropriate P.S.R.O. areas throughout the nation. Areas could cover an entire state (particularly those with smaller population) or parts of a state. But generally a minimum of 300 practicing doctors would be included within one P.S.R.O. area. If, as the system is implemented, changes seem desirable, these first tentative designations may be modified. In addition to designating these areas, the Secretary would also develop prototype review plans, again after consultation with professional and other concerned organizations and interests. HEW would aid in the development of such plans with the view to securing acceptable arrangements for P.S.R.O.'s in all areas and to gain experience with several patterns. Organizations representing substantial numbers of physicians in an area, such as medical foundations and medical societies, would be invited and encouraged to submit plans meeting the requirements of the programs.

An acceptable plan would be one which encompasses in its proposed activities and responsibilities, to the greatest extent possible, physicians engaged in all types of practice—that is, solo, group, hospital and medical school-based practice, etc. The Secretary would approve those plans which can reasonably be expected to improve and expand the professional review process, initially on a conditional basis, not to exceed two years, with the review organizations operating concurrently with the present review system. During this transitional period, carriers and intermediaries (in the case of Medicare) are expected to abide by the decision of the P.S.R.O. This will permit a more complete appraisal of the effectiveness of the conditionally-approved P.S.R.O. In areas where no adequate plan was initially submitted, the Secretary would seek to develop plans through his own efforts, based upon organizations with professional competence, such as state or local health agencies or claims-paying organizations such as carriers and intermediaries if necessary.

Once an organization is accepted the Secretary, with the assistance of the statewide organization and the National Advisory Council, would monitor the performance of the P.S.R.O. plans using statistical and other appropriate means of evaluation. When the Secretary determines that the performance of an organization is unsatisfactory, and his subsequent efforts to bring about prompt necessary improvement fail, he could terminate its participation, after providing appropriate notice and opportunity for administrative hearing. Provider, physician, and patient profiles and other relevant data would be collected and reviewed on an ongoing basis to the maximum extent feasible to identify persons and institutions

that provide services requiring more extensive review.

Norms of Care

Regional norms of care will be used in the review process as routine checkpoints in determining when excessive services may have been provided. The norms would be used to determine the point at which physician certification of need for continued institutional care would be made and reviewed. The initial priority in assembling and using data and profiles will be assigned to those areas most productive in pinpointing problems so as to conserve physician time and maximize the productivity of physician review. The P.S.R.O. would be permitted to employ the services of qualified personnel, such as registered nurses who could, under the direction and control of physicians, aid in assuring effective and timely review.

When advance approval by the review organizations for institutional admission is required, such approval would provide the basis for a presumption of medical necessity for purposes of Medicare and Medicaid benefit payments. However, if the review organization finds that ancillary services provided subsequent to its approval are excessive, payment under Medicare and Medicaid would be denied with respect to such excessive services. If a physician, institution, or other health care supplier fails to seek advance approval where required, this failure may be considered cause for disallowance of claims.

In addition to acting on its own initiative, the re-

view organization will report on matters referred to it by the Secretary. It would also recommend appropriate action against persons responsible for gross or continued over-use of services, use of services in an unnecessarily costly manner, or for inadequate quality of services. It would act to the extent of its authority or influence to correct such improper activities. The Secretary will establish a National Professional Standards Review Council. It will be composed of physicians with a majority selected from nominees of national organizations representing practicing physicians, and, in addition, physicians recommended by consumers and other health care interests. The Council will review the operations of the local area review organizations, advise the Secretary of their effectiveness, and make recommendations for their improvement.

It is my feeling that the Professional Standards Review Organizations have great potential for assuring reasonable professional controls in Medicare and Medicaid, and, in time, in our entire health care system. It represents a real opportunity for organized medicine to control its own destiny, if it can take this responsibility to provide adequate review of standards and practices. This amendment was prepared and perfected in a genuine spirit of concern for meeting the legitimate needs of millions of citizens who depend upon Medicare and Medicaid, the professions concerned with providing health care, and the public interest in general.

I urge you to use your considerable influence to see that it is implemented efficiently and successfully.

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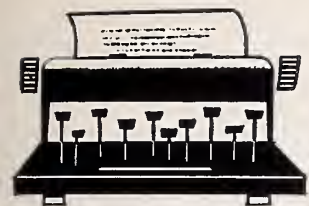
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The Georgia Heart Association

THE GEORGIA HEART ASSOCIATION is the only organization in the state devoted exclusively to the problem of combating some 25 or more different diseases of the heart and blood vessels.

Organized in November of 1948 as an affiliate of the American Heart Association it has since that time attracted national attention in several fields.

The Georgia Heart Clinic System for indigent patients handles more than 16,000 patient-visits per year for persons unable to pay for needed services. (It should be noted that the Association is not a charity nor a welfare organization in the accepted sense of the word. It does not provide financial assistance for individual patients. Its efforts are devoted to fighting heart disease, rather than providing relief. Services of the Clinic System, which the GHA had established in 1949, are possible because more than 150 physician members of the Association contribute approximately 8,000 hours of their time annually to work in the 12 Heart Clinics.)

The GHA established the first state-wide program in the country aimed at the prevention of rheumatic fever.

In 1958 the first state-wide program of stroke rehabilitation in the nation was established by the Georgia Heart Association and has become a pattern for similar activities throughout the country.

One unique feature of the GHA is that it supports research in Georgia Medical centers in addition to its contribution to the national research program of the American Heart Association.

GHA is now supporting 16 teams of investigators at the two medical colleges in Georgia, and its annual grants to research in the past 20 years have totalled over three million dollars; almost a quarter of a million dollars has been awarded to heart research for the twelve month period ending June 30, 1971. About 70 per cent of this amount is for local grants and the balance is for the national research program of the American Heart Association.

One feature of the Georgia Heart Association's research program is its support of a Chair of Cardiovascular Research and an Established Investigatorship at each of Georgia's two medical schools. These Chairs enable the schools to bring to Georgia outstanding research scientists to make a career of heart research in Georgia. Since the GHA's two Chairs were established, 14 other medical schools throughout the country have followed Georgia's lead.

Dr. Elbert P. Tuttle, Jr., and Dr. James B. Hudson hold the Georgia Heart Association Chairs of Cardiovascular Research at Emory University and the Medical College of Georgia, respectively.

Senior Investigators at the two institutions are Dr. Donald O. Nutter and Dr. Martin J. Frank.

Grants-in-Aid were awarded to the following scientists at the Medical College of Georgia, Augusta:

Dr. George R. Bernard—Are the Spontaneous Movements of Lymphatic Vessels Under Nervous Control? A Combined Histochemical and Physiological Attack on the Problem; Dr. Darrell L. Davis—Frequency-Response Characteristics of the Deep Fibular Nerve-Dorsal Pedal Artery Preparation;

Dr. Louis T. Ellison—The Postoperative Open-Heart Patient: An Example of Post-Traumatic Pulmonary Insufficiency; Dr. Martin J. Frank—Investigation of Pre and Postoperative Myocardial Function in Valvular and Non-Valvular Heart Disease.

At Emory University:

Dr. Vardaman M. Buckalew, Jr.—The Pathogenesis of Edema: Possible Role of a Natriuretic Hormone; Dr. John K. Davidson—The Relationship of Glucose and Insulin Metabolism in Obese and Lean Diabetics and Non-Diabetics to the Development of Premature Coronary Artery Disease;

Dr. Mario Di Girolamo—Prevention of Heart Disease by Prevention of Obesity: Studies of the Morphological and Metabolic Consequences of Adipose Organ Enlargement in Obesity.

Dr. W. Dallas Hall—The Occurrence of Fibrin in Circulating Blood Leukocytes and Tissues of Patients Predisposed to Clinical Thromboses.

Dr. Yorimi Matsumoto—Excitation: Contraction Coupling of the Isolated Myocardium Based on Heart Measurement; Dr. John W. Manning—Contributions of Supramedullary Structures to Tonic and Phasic Adjustments of the Cardiovascular System; Dr. Donald O. Nutter—Hormonal Influence on Cardiovascular Dynamics in the Intact Circulation: The Prostaglandins. Dr. Daniel Rudman—Effect of Diabetic Acidosis on the Transport of Drugs, Hormones and Electrolytes by Plasma Proteins.

A statewide program to teach the life-saving technique of cardiopulmonary resuscitation (CPR) is being conducted by the Georgia Heart Association in conjunction with the Georgia Regional Medical Program for paramedical personnel, firemen, policemen, industrial safety personnel and others in high risk and emergency occupations.

To date, 33 active CPR Committees of the Georgia Heart Association are organizing courses throughout the state and 111 counties have trained instructors teaching the method.

Over 10,000 people in Georgia have passed the CPR course, which involves mouth-to-mouth ventilation and external heart compression to restore breathing and heartbeat in victims of accidents which cause these body functions to cease suddenly. Hundreds of cases of successful resuscitation attempts have been reported to the GHA since the CPR Program began two years ago.

LETTERS TO THE EDITOR

Dear Sir:

In reading the November, 1970 issue of the *Journal of the Medical Association of Georgia*, I enjoyed the special article entitled "Medicine and Government" by James W. Harkess, M.D.

In reading this article, it seems to me that this type of information would be most helpful to enlighten the public. Is it possible that the Medical Association could make special efforts to distribute this article to the public in a way that we could be sure that the public would be exposed to it?

William A. Futch, M.D.

Dear Sir:

Please know that I take extreme exception to the radical left thoughts and principles expressed by Kenneth Vaux, Th.D. in the December issue. His views are patently pro-Marxist and defame the basic ideas of our heritage. May the true God of the Judaeo-Christian ethic protect us from radicals such as Vaux.

W. Justus Gower, M.D.



MEDICAL REVIEW AND NEGOTIATING

OUR PSYCHIATRIC COLLEAGUES and psychologists have warned us not to show favoritism to one child or member of the family over another or others, and this is acceptable advice for obvious reasons. By the same token, the Medical Association of Georgia has many excellent and working committees, each of which function and fulfill their assignments without fanfare or public recognition. It is not my purpose to select just one committee to receive an accolade, but I feel at this time it is necessary for our membership to understand that there is a committee of MAG functioning in their behalf full-time.

This major committee is accomplishing a tedious, time consuming and thankless assignment and there is some misunderstanding of the function and action taken by this committee.

The MAG Committee on Medical Review and Negotiating was made a special committee of the Medical Association in 1966; this Committee is composed of a member of each specialty society and the member who represents the specialty society is selected by the specialty society itself to represent the members of that society, as well as all members of MAG.

MEMBERS OF MAG COMMITTEE ON MEDICAL
REVIEW AND NEGOTIATING

Herbert S. Alden, M.D.	Dermatology
Samuel S. Ambrose, M.D.	Urology
Walter S. Dunbar, M.D.	Chest
Richard A. Elmer, M.D.	Radiology
Edwin C. Evans, M.D.	Internal Medicine
Pedro Garcia, M.D.	Psychiatry
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Harvey Hamff, M.D.	Diabetes
William A. Hopkins, M.D.	Thoracic
William E. Huger, M.D.	Plastic Surgery
Charles S. Jones, M.D.	Surgery
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John Roberts, M.D.	Orthopedics
George P. Sessions, M.D.	Anesthesiology
David A. Wells, M.D.	General Practice
C. J. Wyatt, M.D.	Heart
D. S. Strickland, D.O.	Osteopathy

The members of this Committee serve in this very important capacity (as well as the members of the corresponding district and local committees) at their own expense of time and money (as do all MAG members who serve within the confines of the State borders).

Indeed, it is not necessary to remind you that the practice of medicine is as varied in its application as the number of patients seen and you know this, but

the lay individuals who see and process the claims for payment of services must have a more or less "cut and dried" report to properly catalogue and categorize the claim. This means that any report or claim, if not a routine procedure, will require additional explanation as to *why*. This does not mean to question the necessity nor the utilization of the procedure, but just so it can be sorted by a person not familiar with the medical judgments in the treatment of patients. The process of review is certainly nothing new—hospital staff members have been doing it for years. There are and will continue to be instances wherein there is an honest difference of opinion regarding treatment that deviates from the average (or normal) and a black-and-white report with a request for payment requires more information for processing.

If, after submitting additional information, the physician or payee is not satisfied, the claim is submitted to a local committee for review. Claims which cannot be satisfactorily resolved at the local level may, and should be, submitted to the Medical Association of Georgia Committee on Medical Review and Negotiating. If, after due consideration, the claim is still in dispute by either party, it is then submitted to the Executive Committee of Council for final processing; the carriers rely on the Executive Committee to make final judgment, and they will abide by such.

Recently, a "Policy Manual" has been formulated after exhaustive study by the Committee on Medical Review and Negotiating, along with members of the Bureau of Health Insurance and third party carriers and has been duly approved by the Council of MAG. The distribution of this Policy Manual will be to: (1) members of Council; (2) members and alternates of State Review Committees; (3) Chairmen of District and Local Review Committees. A most important paragraph will be found on page two of this manual: "Submission Criteria—Third Party Carriers should submit to Medical Review all claims which exceed usual and customary charges based on the Carrier's physician profile, and all claims which exceed the utilization parameters as designed by the Committee. Physicians may also submit claims to Medical Review which, in their judgment, have been handled in an unreasonable manner."

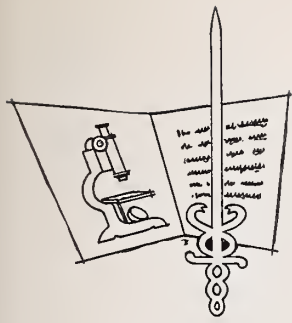
Please cooperate with members of all committees of MAG so that we can maintain as much supervision and control of the practice and business of medicine as possible. If you have a question, or a problem, please call MAG Headquarters, Area Code 404-876-7535, and let us be of help.

Sincerely,

A handwritten signature in dark ink, reading "F. G. Eldridge". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

*F. G. Eldridge, M.D.
President, Medical Association of Georgia*

P.S.—Please, Doctor, read every piece of mail you receive from MAG Headquarters, as it will surely be important to you to do so.



AMERICAN CANCER SOCIETY CANCER RESEARCH IN GEORGIA

JOHN P. WILSON, M.D., *Atlanta*

MEDICAL RESEARCH IN GEORGIA has gained in importance in 1971 with over \$400,000 in Research Grants and Fellowships from the American Cancer Society alone.

This is a great honor for the state since these grants are only awarded to the projects, individuals and institutions judged to be the most superior in the nation. Now when the Federal Government is cutting back its medical research spending, it is especially important that the Cancer Society can supply funds to keep current research projects going and new projects developing. These grants to Georgia's individuals and institutions increase the possibility that a significant breakthrough in cancer research can come from our state.

The funds from the Cancer Society will support three different categories of research. Grants for a specified amount are awarded to a researcher and his team who are working on a specific study. Grants for a specified amount are also awarded to Ph.D. candidates who are working on a specific project. A \$4,800 stipend is awarded as a Clinical Fellowship to doctors who are receiving special cancer training, which they can share with their colleagues and staffs.

Ten grants for research studies and predoctoral projects are now in effect in Georgia.

Seven Clinical Fellowships will be in effect in 1971-72 in Georgia, five at Emory University and two at Georgia Baptist Hospital.

The largest single grant, \$81,805 is held by Dr. Andre J. Nahmias at Emory University School of Medicine. Dr. Nahmias and his research team are studying the relationship between herpes virus infections and cervical cancer. To date, Dr. Nahmias and his team have found that a significant percentage of the women who have cancer of the cervix also have a herpes virus infection or have had it in the past.

Two new grants totaling \$68,140 are awarded to Dr. William R. Vogler at Emory School of Medicine this year. Dr. Vogler is working with substance in the urine and serum of leukemia patients which causes white blood cell precursors to grow and multiply. Normally, the production of white blood cells in the body is precisely regulated. He is studying this substance and the way it causes normally regulated cell growth to become unregulated growth.

Dr. Vogler is also studying the effects of various chemotherapeutic treatments on leukemia patients. He is attempting to solve the current problem in drug treatment that many drugs which slow down the growth of white blood cells in the leukemia patient also affect normally developing cells.

The work of Dr. Gordham L. Patel at the University of Georgia is concerned with the role of proteins of the chromosome in the regulation of genetic activity. This problem is being probed by the use of steroid hormones which are known to activate genetic activity under certain conditions.

Dr. Loren J. Humphrey of Emory School of Medicine is studying the effects of various chemotherapeutic and immunotherapeutic treatments on patients with ovarian cancer.

Dr. Vojin Popovic at Emory School of Medicine is studying the effectiveness of anti-cancer drugs on tumors which remain at body temperature while the body temperature of the rest of the animal is lowered. At Emory School of Medicine, Dr. Gilbert Rinard's research involves treatment of female rats with estrogens followed by a study of the uterus cells to see the changes which develop.

Guy Claude Davis, Douglas D. Ross and Michael T. Snider, all at Emory University are awarded the predoctoral research scholarships.

Clinical Fellowships which will be in effect during the coming year are held by the following—Dr. David H. Vroon and Dr. William H. Holbrook at Emory University and Dr. Charles E. Demby at Georgia Baptist Hospital.

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PENETRATING WOUNDS OF THE HEART

PANAGIOTIS N. SYMBAS, M.D., *Atlanta*

PENETRATING WOUNDS of the chest, caused by stabbing or gunshot, have unfortunately become commonplace and frequently involve injury to the heart and great vessels. The site of entry or exit, although it may strongly suggest the presence or absence of a cardiac wound, is often misleading since precordial penetrating wounds may not be associated with a cardiac wound, whereas cardiac injury may accompany wounds of the lateral chest wall, neck, or abdomen. The pathophysiology of the wound is dependent upon both the type of weapon and wound location. Stab wounds often present with symptoms and signs of cardiac tamponade (agitation, air hunger, cold and clammy skin, distended neck veins, Kussmaul's sign, pulsus paradoxus, and muffled heart sounds) and less frequently with a hemothorax showing massive or continuous bleeding. Bullet wounds of the chest, on the other hand, often present with a serious hemothorax and tamponade, and less frequently with cardiac tamponade alone. Bullet wounds are frequently lethal and probably 50 per cent of patients with such wounds succumb before they receive medical care.

Cardiac tamponade must be suspected in all patients with penetrating trauma and treated aggressively when present. The clinical diagnosis of cardiac tamponade is particularly difficult to make under certain conditions: (a) In a patient with the odor of alcohol on his breath, the symptoms and in particular the neurological manifestations of cardiac tamponade, may be falsely attributed to ethanol intoxication. These patients should be thoroughly examined and cardiac tamponade completely ruled out before they are discharged from a hospital emergency room; (b) In the patients with traumatic hemothorax whose clinical picture and hypotension improves significantly following massive administration of blood volume expanders, cardiac tamponade must be excluded since this problem will also improve following an increase in cardiac filling pressure. In a patient with penetrating chest trauma and shock the presence of distended neck veins and a central venous pressure above 12 cm of saline strongly suggest that the clinical picture may be due to cardiac tamponade. One must also remember that Kussmaul's sign is often absent in patients with tamponade and, conversely, that pulsus paradoxus is frequently associated with hemorrhagic shock in the absence of tamponade. Standard chest films are of no value in the diagnosis of acute cardiac tamponade and fluoroscopy of the chest should be utilized only when the patient's condition is stable. Immediate pericardiocentesis should be performed in the patient presenting with penetrating chest trauma and suspected cardiac tamponade. This procedure will establish the diagnosis of tamponade if nonclotting blood is obtained, and the resultant cardiac decompression provides the first effective treatment for these patients. Pericardiocentesis can result in immediate hemodynamic improvement following withdrawal of as little as 30 ml of blood from the pericardium.

Because rapid and vigorous resuscitative efforts are necessary in the majority of patients with penetrating cardiac wounds, the resuscitation should be carried out by more than one physician whenever possible. The administration of intravenous fluid or blood, insertion of a central venous catheter, pericardiocentesis,

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

and drainage of the pleural space should be done with great rapidity when indicated. The pericardiocentesis is preferably performed through the left paraxiphoid approach and with constant electrocardiographic monitoring. The electrocardiogram, however, should be utilized only when it will not unduly delay the pericardiocentesis. When pericardiocentesis is effective in the patient with a cardiac stab wound, the patient should be transferred to an area close by the operating room for further observation and monitoring. If, however, pericardiocentesis is ineffective or tamponade reappears, thoracotomy should be performed as soon as possible. Repeat pericardiocentesis is recommended only for the safe transfer of the patient to the operating room or if facilities and personnel for thoracotomy and cardiorrhaphy are not available. Thoractomy should be performed as soon as possible in patients with bullet wounds of the heart, and pericardiocentesis should be used only to provide safe transfer of the patient to the operating room.

The management of penetrating cardiac trauma does not end with the repair of the chest wound and pericardial and pleural drainage. Serial physical examination of the patient in the hospital and following discharge is indicated for the early detection of "post pericardiotomy syndrome" (a common sequelae to penetrating cardiac wounds) and of residual traumatic defects including ventricular septal defect, valvular regurgitation, and aorta to pulmonary artery fistula. Cardiac catheterization should be performed when these defects are suspected and elective surgical correction considered in those patients with hemodynamically significant defects.

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CIVIL LIABILITY FOR BLOOD TRANSFUSIONS

WILLIAM L. GOODWIN, *Atlanta*

THERE IS CURRENTLY NO METHOD by which to detect the presence of serum hepatitis virus in blood to be used for transfusions. Under conventional legal theories, courts generally refused to impose liability for contraction of hepatitis due to blood transfusions upon hospitals or non-profit blood banks which supply the blood. Recently, however, the highest courts of Pennsylvania and Illinois have made suppliers of blood liable on theories of liability without negligence.

Implied Warranties

Since in cases of transmission of hepatitis by transfusion, no liability can factually be predicated upon negligence, plaintiffs have sought to base liability upon a breach of "implied warranties"—those warranties which the seller is automatically deemed to have extended to the buyer in a sales transaction. Thus, a restaurateur impliedly guarantees his customer that the food he dispenses, deemed to be the subject of a sales transaction, is "merchantable," *i.e.*, of standard quality, and fit for its particular purpose, namely, human consumption.

Under traditional notions of sales transactions and accompanying implied warranties, a distinction was drawn between a sales transaction and a service transaction. Commodities supplied only incidentally in conjunction with the rendition of a service carried no implied warranties, since such warranties did not apply to the services themselves. Until recently, the courts ruled in near unison that the supplying of blood was not a sales transaction to which implied warranties were applicable, but, instead, constituted medical services, liability for which was accordingly limited to cases where negligence was proven. The Georgia Court of Appeals adopted this position, which it termed the "overwhelming majority view," in the 1967 case of *Lovette v. Emory Hospital, Inc.* Moreover, the legislatures of some 25 states have enacted statutes legislatively declaring blood transfusions to be services rather than sales.

Recent Departures

The trial court in the recent Pennsylvania case had followed precedent and dismissed the plaintiff's suit, based upon implied warranties, on the grounds that blood transfusions constituted services rather than sales. However, the Supreme Court of Pennsylvania vacated the trial court's decision, stating that the sale-service distinction was no longer determinative of whether implied warranties were extended in connection with blood transfusions. The Supreme Court returned the case to the trial court for the latter's determination of "whether the policies for which warranties are implied in law would be furthered by applying the warranties to blood transfusions."

Taking a somewhat different approach, the Illinois Supreme Court in its recent decision held the defendant hospital liable under the same legal theory of "strict

* Prepared at the request of The Medical Association of Georgia. Mr. Goodwin is an associate in the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

liability without fault" which is applied to manufacturers and distributors of consumer goods: if a product (blood) is supplied by an enterprise (hospital) in the business of supplying such product, and the product contains a defect (serum hepatitis virus) at the time it leaves the hands of the supplier, then such supplier is liable for the damages caused by the use of the product notwithstanding any lack of negligence on its part. The rationale behind such "strict liability" doctrines is one of risk-allocation; it is thought that the supplier of consumer products is in a better position to insure against unavoidable injuries resulting from their use than is the individual consumer. But when such a doctrine is applied to the supplying of blood, the practical consequence is an increase in the already near-prohibitive cost of hospital services to all patients.

Recommendation for a Legislative Solution

It is unlikely that the Georgia courts will take it upon themselves to extend the liability of medical practitioners and institutions by abrogating the relevant rules of law as have the courts of some other states. On the other hand, it has become apparent that the mere characterization of blood transfusions as services rather than sales transactions may not necessarily answer the principal question—whether or not liability without negligence is to apply to such medical services.

A bill has been introduced in the current session of the Georgia General Assembly which specifically provides that liability for the furnishing of blood and other human tissue for transfusion or transplant shall be determined according to whether the defendant was negligent in the supplying of such materials. This statute would not in any way deprive an injured patient of his rights against a negligent or unauthorized practitioner or institution, but, instead, preserves the proper allocation of (as yet) unavoidable risks involved in such medical services. As the Minnesota Supreme Court pointed out in deciding that hospitals are not liable in such cases, "It is a matter of medical judgment to determine whether in a particular case the benefits (of a blood transfusion) outweigh the risks."

Doctrines of "strict liability" are incompatible with the realities of providing skilled and individualized medical care.

Suite 1220
C & S Bank Building

JUST MEDICINE IN CRISIS?*

There have been many explanations as to why the general public has become disenchanted with the medical profession. To be sure, a doctor is no longer worshiped with the same reverence that I can recall as a child. But can we as physicians accept all the credit for being demoted from divine healers to fallible human beings? The most common reasons given for our present state of decline are related to unjust charges: inadequate medical care to certain groups of people, the attitudes of the AMA, the communications media, et cetera. It has also been said that medical science has not come up with sufficient cures for the money spent on research. We have been accused of becoming overspecialized, impersonal and too wealthy.

I am not about to try to disprove these statements. The AMA does this better than I can. "Where there is

smoke, there is fire." (I don't know who said that, Confucius or Freud or someone.) Many of these accusations are true and do require some adjustments on our part. But the question is, whether these adjustments are to be made on the basis of image boosting. If we were to treat only the poor, if we were to become less specialized, if we were to become severely ascetic and refuse all recompense, if we were to make house calls, would we improve our image? I doubt it.

Deflating as it might be, we can not accept full responsibility for our present plight. Cliched and hackneyed as it sounds, our image is as much a "projection" of society as it is objectively determined. Few professions or occupations have escaped the butchers' blocks of contemporary judgment. Is the legal profession held in any great esteem? What about educators? It is interesting that society has not broken covenant with the commandment, "Honor thy teacher as you

* Reprinted from *The Bulletin of the Georgia Medical Society*, Savannah, Ga., Vol. X:12 (December) 1970.

But this is not all. Even if this were not the case:

Most people still enter the medical profession out of love for what they do. Doctors are still ethical, intelligent, and dedicated. The fact that they make a living is unpopular today, but there are easier ways to get wealthy. As physicians we make mistakes. That is a mortal attribute; to correct these faults is also. We can only hope that after being leveled to mortal size, that we will be accepted as human beings rather than being criticized for being human. How can society expect us to go back to playing God when it was they who reclaimed our divine powers and made us mortal?

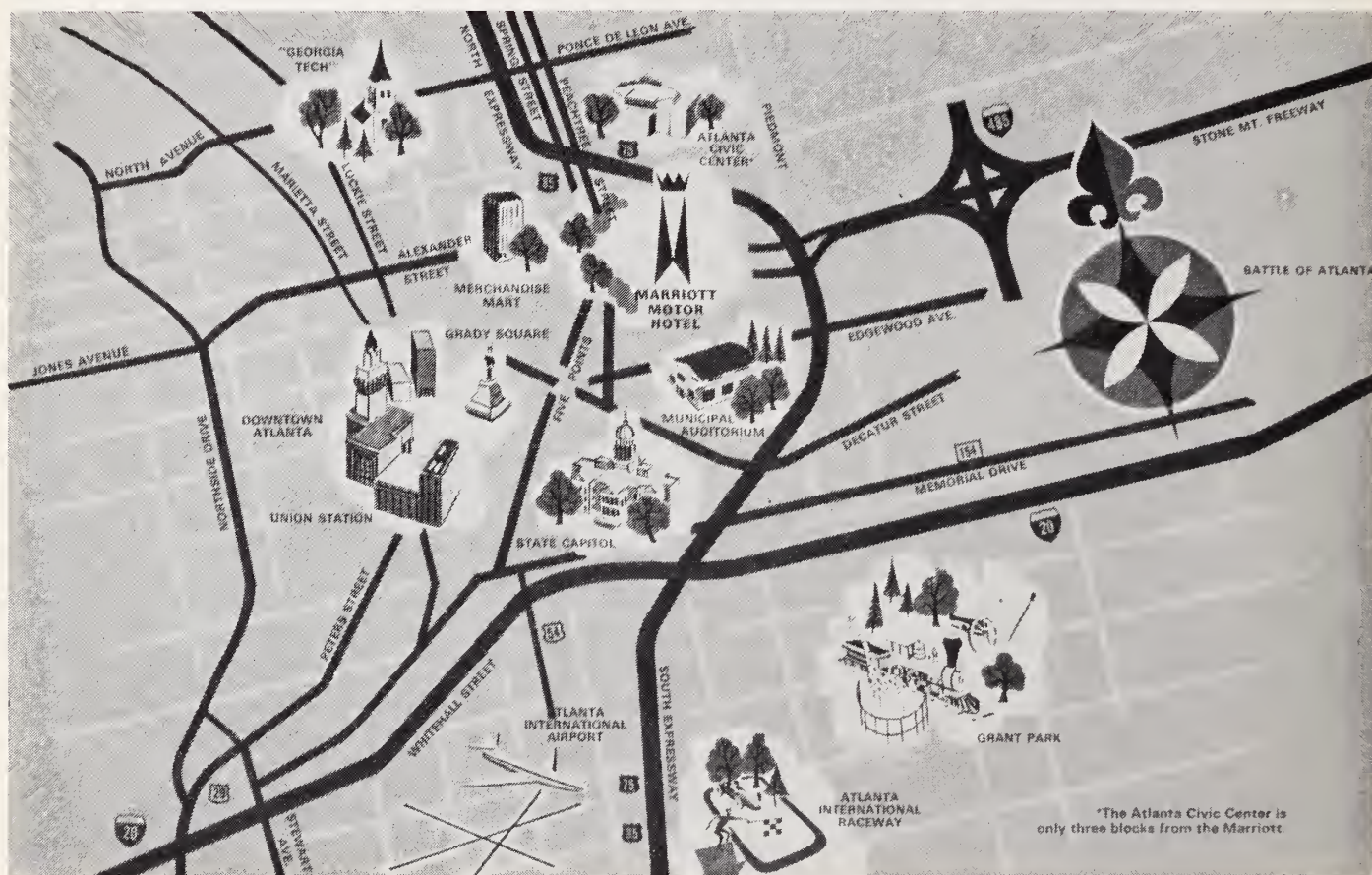
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Come to Atlanta in May



THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 13, 1971

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 14, 1971

- 9:00 a.m.—First General Session
First Session, House of Delegates
General Meeting
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—Health Care"

- 6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 15, 1971

- 9:00 a.m.—Reference Committee Meetings
- 9:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—The Drug Scene"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 16, 1971

- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia Annual Session

May 13-16, 1971—Atlanta, Georgia
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1. Please complete this form and mail directly to: Reservation Department
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MAY 13-16, 1971

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Barry, Carole J. Active—Fulton—P	1000 Johnson Ferry Rd., N. E. Atlanta, Georgia 30305
Batchelor, Curtis A. Active—C-D-H—GP	405 Alabama Street Bremen, Georgia 30110
Bradley, Charles K. Active—OPH—Hall	1128 Vine Street Gainesville, Georgia 30501
Brown, Audrey K. Active—Richmond—PD	Medical College of Georgia Augusta, Georgia 30902
Brylski, James R. Active—Fulton—NE	980 W. Kingston Dr., N. W. Atlanta, Georgia 30305
Cooper, Lawrence E. DE-2—Fulton—HE	1460 Mt. Paran Rd., N. W. Atlanta, Georgia 30327
Davis, William A., III Active—Fulton—R	35 Linden Ave., N. E. Atlanta, Georgia 30308
Evans, Eugene G., Jr. Active—Muscogee—P	2000 16th Ave. Columbus, Georgia 31901
Harper, William F. Active—Dougherty—SU	500 N. Slappey Blvd. Albany, Georgia 31701
Hatch, Joseph C. Active—S. Ga.—SU	Adel, Georgia 31620
Heath, George S. Active—Ware—GP	701 Elizabeth Street Waycross, Georgia 31501
Kelly, Elmo C., III Active—Dougherty—D	308 Residence Ave. Albany, Georgia 31701
Mayher, William E., Jr. Active—Dougherty—NS	419 Fourth Ave. Albany, Georgia 31705
Pemberton, L. Beaty Active—Muscogee—SU	Medical Center Columbus, Georgia 31901
Puryear, Gordon H. Active—Richmond—TS	Talmadge Memorial Hospital Augusta, Georgia 30902
Rico, Jorge E. Active—Richmond—Anes	Medical College of Georgia Augusta, Georgia 30902
Selmonosky, Carlos A. Active—Richmond—TS	Medical College of Georgia Augusta, Georgia 30902
Shirley, Jacob L., Jr. Active—Dougherty—GP	411 S. Madison St. Albany, Georgia 31701
Sosby, John T. Active—Coweta—OBG	15 Cavender Street Newnan, Georgia 30263

Tramblie, William G. Active—South Georgia— SU	116 Hospital Drive Lakeland, Georgia 31635
Walker, Jerome M., Jr. DE-2—DeKalb—N	755 Columbia Drive Decatur, Georgia 30030
Wright, J. Carter Active—C-D-H—SU	624 Dixie Street Carrollton, Georgia 30117
Yarbrough, Sidney H., III Active—Muscogee—OR	1310 13th Ave. Columbus, Georgia 31901
Zeigler, Francis M., Jr. Active—Dougherty—Anes	Phoebe Putney Hospital Albany, Georgia 31705

PERSONALS

First District

Irving Victor and **Cheng-Tsuau Su** have announced the formation of the Urological Association of Savannah, in December.

Third District

W. Lloyd Hudson, Jr., has been elected to fellowship in the American Academy of Pediatrics.

Fifth District

Edgar Boling was named first vice president of the Southern Medical Association at that organization's 64th annual meeting in November.

John E. Skandalakis donated a commissioned bust of Hygieia to the Center for Disease Control in December.

Nanette K. Wenger participated in a roundtable discussion on "Coronary Heart Disease" held in Miami, Fla., in December. Comments from participants in the discussion will serve as the basis for a future feature article in *Patient Care* magazine.

Eighth District

Charles H. Durden has been elected to active membership in the American Academy of General Practice.

Malcolm T. McGoogan was elected president of the Waycross and Ware County Chamber of Commerce in December.

Ninth District

John C. Lawrence has been certified as a diplomate of the American Board of Pediatrics.

DEATHS

Louie H. Griffin, Sr.

Louie H. Griffin, Sr., member of the Georgia State Board of Health from the First Congressional District, died January 10 in Claxton after a long illness.

First appointed to the State Health Board in 1967 to fill an unexpired term in the First District, Dr. Griffin was re-appointed by Gov. Maddox in 1969 to serve a full six-year term.

Born in Gibson, Ga., Dr. Griffin attended the University of Georgia and received his M.D. degree from the Medical College of Georgia in 1937. After completing an internship and residency at Warren A. Candler Hospital in Savannah, he began the private practice of general medicine and surgery in Claxton. He practiced in Claxton since that time with an interruption from 1941-45 for a tour of duty with the United States armed forces. In 1953, he opened a private general medicine and surgery hospital in Claxton.

Dr. Griffin was a member and past president of both the Bulloch-Candler-Evans County Medical Society and the First District Medical Society. He was also past president of the Alumni Association of the Medical College of Georgia, and a member of the Medical Association of Georgia, the Southern Medical Association, and the American Medical Association.

He served as chairman of the board of deacons of the First Baptist Church of Claxton and as president and member of the board of the Bank of Gibson. Dr. Griffin was a Mason, Shriner and Rotarian.

He is survived by his widow, the former Cleo Clark; a son, Louie H. Griffin, Jr., M.D., and two daughters, Deborah Lynn Griffin and Jeanne Griffin Starnes.

Bert H. Malone

Bert H. Malone died December 15 at his home in Brunswick after a short illness. He was 59.

He was graduated from the University of Georgia and attended the Medical College of Georgia for three years, receiving his medical degree from Louisiana State University.

Dr. Malone served his internship at Charity Hospital in New Orleans and did a year of graduate work at Johns Hopkins University Hospital in Baltimore, Md.

After serving four years in the U.S. Army he specialized in radiology, spending a three-year residency

at Jefferson Medical College in Philadelphia, Pa., and Memorial Hospital for Cancer and Allied Diseases in New York, N.Y. Upon completion of this program, he practiced in Jacksonville, Fla. until 1952 when he moved to Brunswick. Dr. Malone was radiologist for Glynn-Brunswick Memorial Hospital and maintained a private practice, also.

Dr. Malone was a member of St. Mark's Episcopal Church, where he was a vestryman and had served as both junior and senior warden of the church. He was a member of the Brunswick Rotary Club and had served as director. He was on the board of directors for the United Community Fund for Brunswick and Glynn County and was a past master of Ocean Lodge No. 214 F&AM.

He was past president of Glynn County Medical Society, former chief of the medical staff of Glynn-Brunswick Memorial Hospital, past president of the Georgia Radiological Society and for five years had served as counselor from Georgia for the Radiological Society of North America.

Dr. Malone is survived by his widow, Mrs. Violet Gascock Malone; two daughters, Mrs. Dorothy Malone Miller and Mrs. Anne Malone Boney, both of Brunswick; a foster son, Mike Manning of Athens; a sister, Mrs. John Burroughs of Norfolk, Va. and a grandson.

Thomas F. O'Donnell

Thomas Francis O'Donnell, public health director for the district of Seminole, Decatur and Early counties, died December 22 after a lengthy illness.

A native of Waterbury, Conn., he moved to Bainbridge from Waycross in 1961. He was a member of St. Joseph's Catholic Church, the American Medical Association, the Decatur-Seminole Medical Society, Medical Association of Georgia, and the Bainbridge Country Club.

Dr. O'Donnell is survived by his widow, Mrs. Frances Smith O'Donnell and two sons, William James O'Donnell of Carlsbad, Calif., and Robert Lee O'Donnell, Washington, D.C.

CALL FOR SCIENTIFIC EXHIBITS

117TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Atlanta, Georgia, May 13-16, 1971

For Information and Application, Write:

**John McClure, Jr., M.D., Chairman
MAG Scientific Exhibits Committee
938 Peachtree Street, N.E.
Atlanta, Georgia 30309**

MAG ART SHOW

The Medical Association of Georgia and the Woman's Auxiliary in Atlanta invite you to participate in the Art Show to be held at the 1971 Annual Session of the Medical Association of Georgia. A large number of works of art have been inspired by the field of medicine. Art has proven to be a faithful mentor to the medical historian who has steadily drawn on it in order to gain a completely valid picture of the doctor and his patient. The concepts of disease have also been illustrated in art. There can be no doubt that the contributions of art to medicine have been numerous. We know that as art has benefited the medical profession there are valuable contributions to be made by medical families to the field of art. Our purpose is to inspire a greater interest in the arts and to gain your participation in the MAG Art Show.

This event will take place on May 13-16, 1971 at the Marriott Motor Hotel in Atlanta. Art Exhibits will be set up on Wednesday, May 12 from 8:30 to 5:00 p.m. MAG Art Show Guidelines follow and further information can be obtained by writing Mrs. Pano A. Lamis, 3703 Peachtree Road, N. E., Atlanta, 30305.

Mag Art Show Guidelines

1. Eligibility: Any member of the MAG, their spouse, or member of the immediate family.
2. Each exhibit may be entered by the artist in one or more of the following classes:

1. Oil or Acrylics
2. Watercolours
3. Photography
4. Sculpture
5. Arts and Crafts

3. An exhibitor may show two pieces in each class, but not more than six pieces in any exhibition.

4. No piece may be shown at more than two exhibitions.

5. In any exhibition no participant may be awarded more than one prize at any annual exhibition.

6. The Judges' decisions are final.

7. The Art Show Committee has the right to not exhibit any piece which is judged by them not suitable for exhibition.

8. Medical pieces designed to illustrate anatomical or pathologic conditions are not acceptable.

9. All entries are accepted with the understanding that the artist assumes all responsibility for the piece exhibited.

10. All pieces will be on exhibit by 2:00 p.m. of the opening day of the Annual Session and remain until adjournment of the Annual Session.

11. Judging will take place on the first day of the exhibit. The chairman of the Art Show Committee shall accompany the judges, providing the Chairman has no exhibit in the show. Otherwise, an impartial member of the Art Show Committee will accompany the judges of the show. No exhibitor will be permitted at the judging or in the area of the show at this time.

12. All entries are accepted with the implicit understanding that the artist assumes all responsibility for the piece exhibited.

13. All paintings must be framed and ready for hanging.

14. All photographs except transparencies must be matted but unframed.

—The lowest priced tetracycline—nystatin combination available—



15. Exhibitors of transparencies must provide their own light source.

16. Space for exhibits will be provided for by the Annual Sessions Committee of the MAG.

17. The Annual Sessions Committee will budget \$100.00 for prizes to be awarded by the Arts Committee.

18. Exhibits by children of an MAG member will be judged in a separate category and prizes awarded accordingly.

19. The Chairman of the Arts Committee, or designee, will present the awards at the annual banquet.

20. The Committee will have the responsibility for receiving and registering of all exhibits and provide means for exhibiting of all entries.

21. Security for the Art Show will be provided for by the Annual Sessions Committee.

22. Prizes awarded should be First, Second, and Third awards and appropriate ribbons attached to the exhibit.

THE MONTH IN WASHINGTON

The federal government now has the authority to expand the U.S. Public Health Service to provide direct medical and other health care services in ghettos and rural areas where there are shortages of physicians and other health personnel.

Before such a program can be started, the state and local medical society must certify that it is needed.

The Senate approved the authorizing legislation, 66 to 0, and the House by an almost unanimous voice vote. President Nixon signed it into law on Dec. 31 although the secretary of Health, Education and Welfare, and the PHS surgeon general had asked Congress to defer action until the President had presented his overall health program early this year.

The legislation authorized \$10 million for the current fiscal year ending next June 30, \$20 million for fiscal 1972 and \$30 million for fiscal 1973. The money must be appropriated before it is available for the program.

Revitalize PHS

In its report approving the legislation, the House commerce committee expressed a hope that it would help revitalize the PHS which the Nixon Administration reportedly has been planning to further downgrade, or even eliminate, in a reorganization of the health activities of HEW.

"That the Public Health Service has been allowed to languish, and that the great functions it has performed have largely been stripped from it, is the fault of this and previous administrations, and a tragedy from the standpoint of the nation's health needs," the committee report said.

Physicians enlisting in the program will become PHS commissioned officers and, as such, be exempt from the military draft. Fees paid for their services will be set by the HEW secretary and go into the U.S. treasury.

The HEW secretary has the responsibility of determining, after consultation with local officials and health groups, what areas need such a program. He then can assign PHS personnel there after receiving a request from a state or local health agency or other public or nonprofit private health organization and a certification of need from the state and local medical society.

The new law—the "Emergency Health Personnel Act of 1970"—also provides for the establishment of a 15-member National Advisory Council on Health Manpower Shortages. It will include three members from

the health professions, three members from state health or health planning agencies and four from the general public representing consumers of health care.

Presidential Physical

President Nixon was pronounced in "excellent health" with a "young man's blood pressure" after his annual physical checkup.

Air Force Brig. Gen. Walter Tkach, M.D., the President's physician, said that all the tests given the nation's chief executive at the Bethesda (Md.) Naval Medical Center were within normal limits. The examination team of five physicians including himself, Tkach said, found Nixon's blood pressure to be 118/82 compared to last year's reading of 120/80. He described it as a "young man's blood pressure, ideal" for the President who was only 10 days short of his 58th birthday.

Tkach's only recommendation for Nixon was that he take more time for exercise and recreation, preferably in California or Florida. The President partly heeded the advice, going to California shortly thereafter for a "working vacation."

Combat Diseases

Three major reports before the federal government urge extensive programs to combat cancer and heart disease.

A special panel of 26 expert consultants, in a report to the Senate Labor and Welfare Committee, urged a multi-billion dollar crusade against cancer in an effort to erase its "staggering" impact of death and suffering caused by the disease.

The National Advisory Cancer Council urged increased educational efforts by both governmental and private agencies to warn the public against the hazards of smoking.

The Inter-Society Commission for Heart Disease Resources recommended a program that would promote drastic changes in the nation's dietary habits, elimination of cigarette smoking and research into the causes of high blood pressure.

The latter two bodies were set up by the Department of Health, Education and Welfare. The heart disease commission is made up of more than 100 experts in cardiovascular disease, epidemiology, radiology, rehabilitation and surgery from 29 medical organizations, including the American Medical Association, the American Heart Association, the American Nurses Association, the American Hospital Association and the College of Cardiology.

WASHINGTON / Continued

Based on a four-month study, the cancer report to the senate committee included an estimate that 50 million Americans now living will develop the disease and that 34 million of them will die unless immediate steps are taken to curb it.

Recommendations

The consultants recommended a sweeping program keyed to consolidation of all existing cancer research projects into a national cancer authority directly responsible to the President.

"The Committee is unanimously of the view that the conquest of cancer is a realistic goal if an effective national program along the lines in the report is promptly initiated and relentlessly pursued," said Benno C. Schmidt, co-chairman of the group.

The report recommended doubling cancer research spending to \$400 million in the 1972 fiscal year, and increasing it by \$100 million to \$150 million in subsequent years to a \$1 billion level in 1976.

The panel of consultants, which included labor and civic leaders as well as distinguished cancer researchers, said that the program should be devoted primarily to research into the causes and cures of cancer, rather than to patient care.

Cancer Epidemic

The National Advisory Cancer Council's fourth annual report on the state of the art in cancer research cited the more than 60,000 deaths a year in the United States from an "epidemic" of lung cancer attributed

mainly to cigarette smoking. The report dealt with the chemical causes of cancer and the effects of many environmental factors, not only the "private pollution" of smoking but also the more public air pollution from industrial and commercial wastes, as causative agents in malignant disease.

As of January 2, a ban on all advertising of cigarettes on television and radio became effective under legislation approved in the Congress, and all packages of cigarettes manufactured and sold in the United States now must carry a new printing warning: "The Surgeon General has determined that cigarette smoking is dangerous to your health." This replaced the milder warning required by a 1965 law that expired in 1969 which said: "Caution: cigarette smoking may be hazardous to your health."

Although a substantial portion of this report of the Council was devoted to the problem of smoking and health, it was stated that the production of cancer by chemicals is part of a larger problem of the hazards facing man in a polluted environment. The report pointed out that the death rate from cancer continues to increase despite steady improvement in the cure rate, and suggested that this may be related largely to increased exposure of the population to cancer-causing agents in the environment.

The heart disease commission's report said the nation's cholesterol-rich diet, cigarette smoking and high blood pressure are the primary reasons for one million heart attack deaths and 600,000 heart disease deaths in the United States annually. The report cited five secondary factors: obesity, diabetes, tensions, sedentary living and heredity.

Announcing the Thirty-Fourth Annual Meeting of THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—The Roosevelt Hotel—March 8, 9, 10, 11, 1971

GUEST SPEAKERS

Chas. Ronald Stephen, M.D., Dallas, Tex.
Anesthesiology
Alejandro F. Castro, M.D., Washington, D.C.
Colon and Rectal Surgery
Alexander A. Fisher, M.D., Woodside, L.I., N.Y.
Dermatology
Thomas P. Almy, M.D., Hanover, N.H.
Gastroenterology
Jack H. Hall, M.D., Indianapolis, Ind.
General Practice
Denis Cavanagh, M.D., St. Louis, Mo.
Gynecology
John T. Galambos, M.D., Atlanta, Ga.
Internal Medicine
Roger F. Palmer, M.D., Miami, Fla.
Internal Medicine
Nathan S. Schlezinger, M.D., Philadelphia, Pa.
Neurology

Ernest W. Page, M.D., San Francisco, Calif.
Obstetrics
Henry F. Allen, M.D., Boston, Mass.
Ophthalmology
Phillip L. Day, M.D., San Antonio, Tex.
Orthopedic Surgery
Edley H. Jones, M.D., Vicksburg, Miss.
Otolaryngology
John A. Shively, M.D., Columbia, Mo.
Pathology
Max D. Cooper, M.D., Birmingham, Ala.
Pediatrics
William B. Seaman, M.D., New York, N.Y.
Radiology
Robert S. Litwak, M.D., New York, N.Y.
Surgery
Edward R. Woodward, M.D., Gainesville, Fla.
Surgery

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Urology

Lectures, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by the American Academy of General Practice.

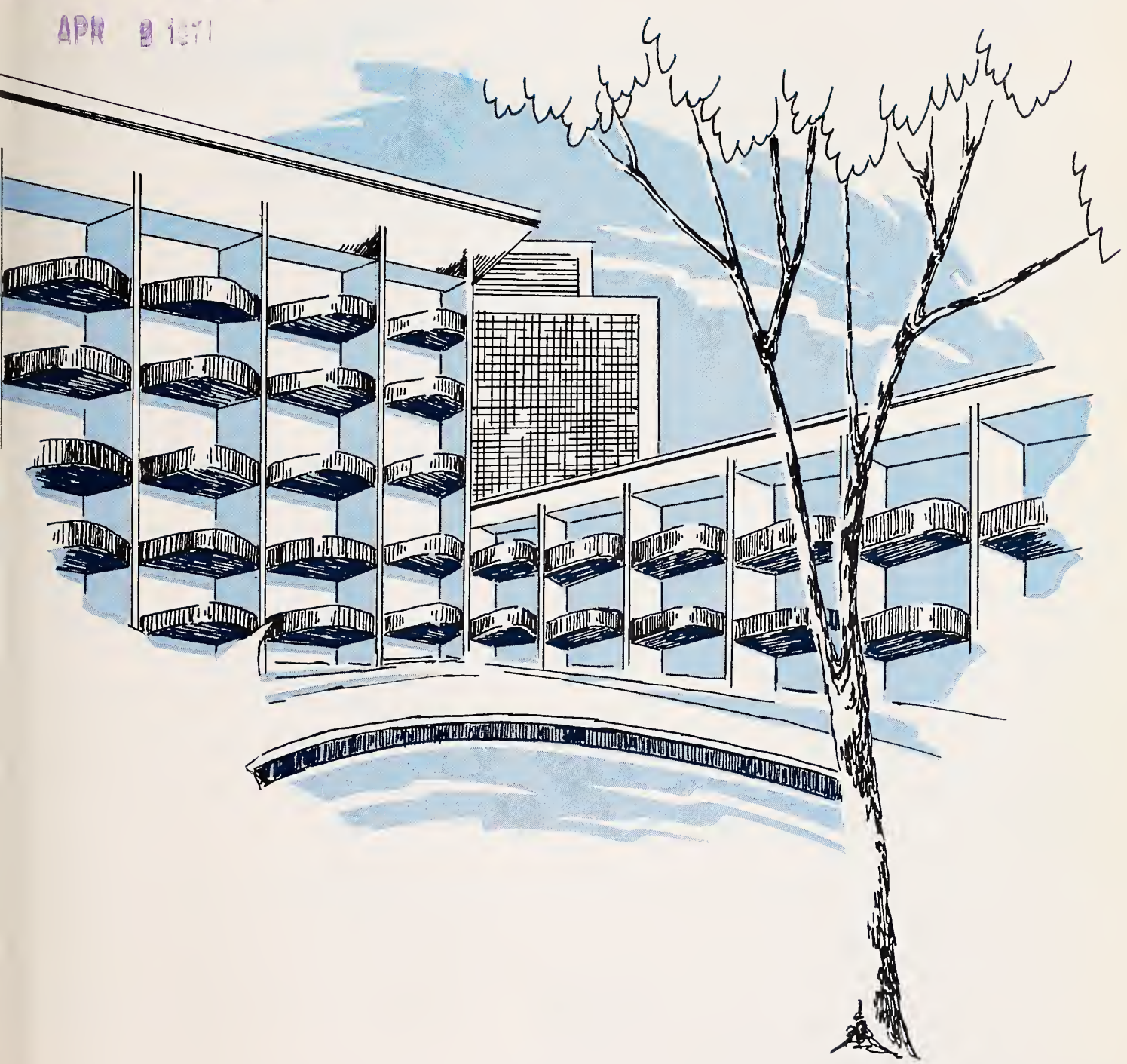
(All-inclusive registration fee—\$35.00)

For information concerning the Assembly meeting write Secretary,
The New Orleans Graduate Medical Assembly, Room 1538,
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Georgia

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APR 8 1971



1971 ANNUAL SESSION
HEADQUARTERS HOTEL

117 ANNUAL SESSION

See page 65

IF MORE MEN CRIED

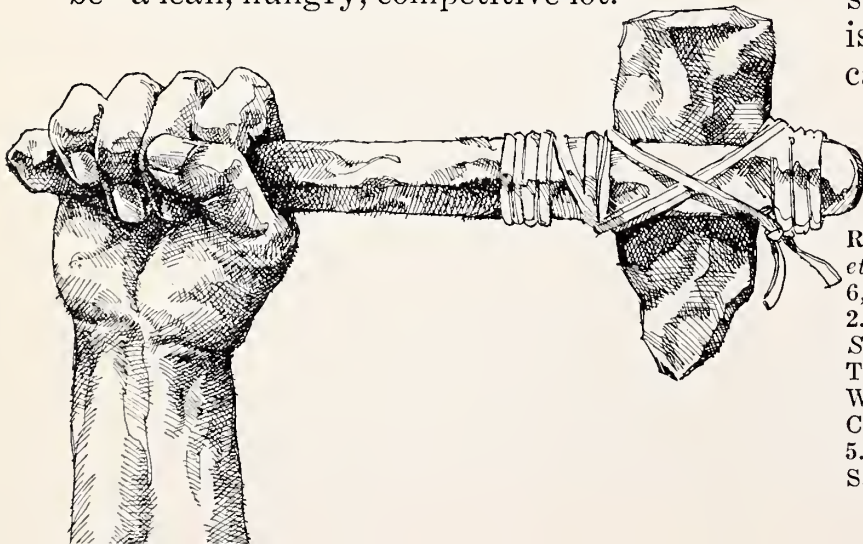


At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."²

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."³



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total

of their genes and what they are taught. Schottstaedt observes that when a mother admonishes a son who has hurt himself that big boys don't cry, she is teaching him stoicism.⁴ Crying is the negation of everything that society thinks of as manly. A boy starts defending his manhood at an early age.

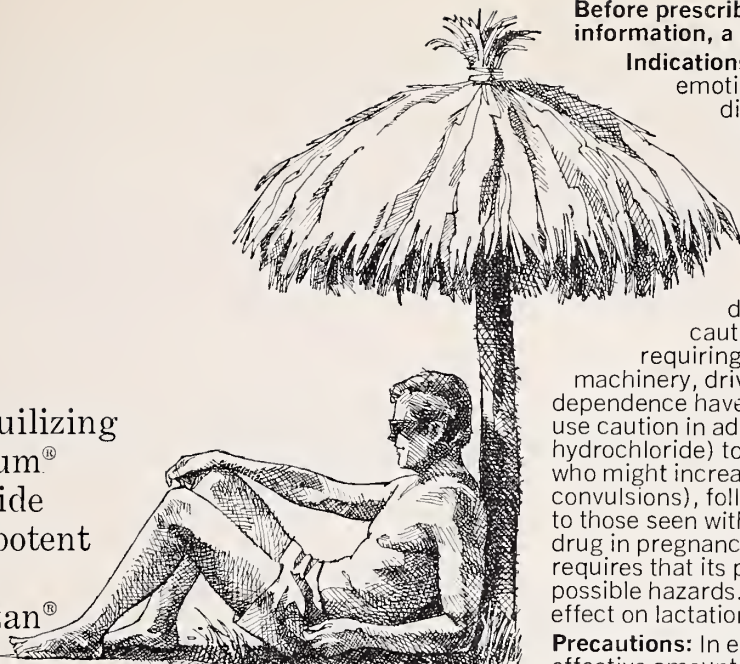
Take away stress, you can take away symptoms.

There is no question that stress plays a major role in the etiology of duodenal ulcers. Alvarez⁵ observes that many a man with an ulcer loses his symptoms the day he shuts the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax.[®] For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that can

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. et al. (eds.): *Harrison's Principles of Internal Medicine*, 6, New York, McGraw-Hill Book Company, 1970, p. 14. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C. Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 3. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.

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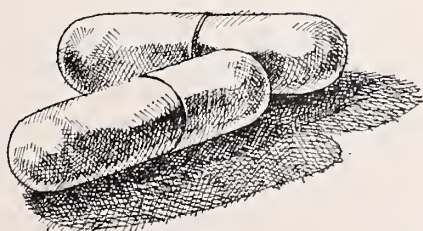


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or 2 capsules, 3 or 4 times daily.** Of course,
there's more to the treatment of duodenal
ulcer than a prescription for Librax. The pa-
tient—with your guidance—will have to ad-
apt to a different pattern of living if treat-
ment is to succeed. During this adjustment
period, 1 or 2 capsules of Librax 3 or 4 times
daily can help establish a desirable environ-
ment for healing.

Librax: It can't change man's nature.
But it can usually make it easier for men to
cope with the discomfort of stress—both
psychic and gastric—that can precipitate
and exacerbate duodenal ulcer.

Librax: Rx #60 1 cap. *a.c.* and 2 *h.s.*



**Before prescribing, please consult complete product
information, a summary of which follows:**

Indications: Indicated as adjunctive therapy to control
emotional and somatic factors in gastrointestinal
disorders.

Contraindications: Patients with glaucoma;
prostatic hypertrophy and benign bladder
neck obstruction; known hypersensitivity to
chlordiazepoxide hydrochloride and/or
clidinium bromide.

Warnings: Caution patients about possible
combined effects with alcohol and other CNS
depressants. As with all CNS-acting drugs,
caution patients against hazardous occupations
requiring complete mental alertness (e.g., operating
machinery, driving). Though physical and psychological
dependence have rarely been reported on recommended doses,
use caution in administering Librium (chlordiazepoxide
hydrochloride) to known addiction-prone individuals or those
who might increase dosage; withdrawal symptoms (including
convulsions), following discontinuation of the drug and similar
to those seen with barbiturates, have been reported. Use of any
drug in pregnancy, lactation, or in women of childbearing age
requires that its potential benefits be weighed against its
possible hazards. As with all anticholinergic drugs, an inhibiting
effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest
effective amount to preclude development of ataxia, over-
sedation or confusion (not more than two capsules per day
initially; increase gradually as needed and tolerated). Though
generally not recommended, if combination therapy with other
psychotropics seems indicated, carefully consider individual
pharmacologic effects, particularly in use of potentiating drugs
such as MAO inhibitors and phenothiazines. Observe usual
precautions in presence of impaired renal or hepatic function.
Paradoxical reactions (e.g., excitement, stimulation and acute
rage) have been reported in psychiatric patients. Employ usual
precautions in treatment of anxiety states with evidence of
impending depression; suicidal tendencies may be present and
protective measures necessary. Variable effects on blood
coagulation have been reported very rarely in patients receiving
the drug and oral anticoagulants; causal relationship has not
been established clinically.

Adverse Reactions: No side effects or manifestations not seen
with either compound alone have been reported with Librax.
When chlordiazepoxide hydrochloride is used alone, drowsi-
ness, ataxia and confusion may occur, especially in the elderly
and debilitated. These are reversible in most instances by
proper dosage adjustment, but are also occasionally observed
at the lower dosage ranges. In a few instances syncope has
been reported. Also encountered are isolated instances of skin
eruptions, edema, minor menstrual irregularities, nausea and
constipation, extrapyramidal symptoms, increased and
decreased libido—all infrequent and generally controlled with
dosage reduction; changes in EEG patterns (low-voltage fast
activity) may appear during and after treatment; blood dyscra-
sias (including agranulocytosis), jaundice and hepatic dys-
function have been reported occasionally with chlordiazepoxide
hydrochloride, making periodic blood counts and liver function
tests advisable during protracted therapy. Adverse effects
reported with Librax are typical of anticholinergic agents, *i.e.*,
dryness of mouth, blurring of vision, urinary hesitancy and
constipation. Constipation has occurred most often when
Librax therapy is combined with other spasmolytics and/or low
residue diets.

**in the treatment of
duodenal ulcer**

**adjunctive
Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

JOURNAL OF THE MEDICAL ASSOCIATION

Georgia

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MAG Annual Session Headquarters Hotel. Design by Marie Seaman.

117th Annual Session Official Call

*Extended to All Officers and Members
of the Medical Association of Georgia*

WELCOME to the 117th Annual Session of the Medical Association of Georgia, at Atlanta, the Gate City of the South.

General Sessions

The opening session will be called to order by F. G. Eldridge, M.D., Valdosta, President of the Association, at 9:00 a.m., Friday, May 14, in the Ballroom of the Marriott Motor Hotel. The Presentation of Colors will be conducted and the National Anthem played.

A Welcome by the Fulton County Medical Society President, Robert E. Wells, M.D., will be followed by a Welcome to Atlanta by a city official. Reports from the Woman's Auxiliary and the Georgia Student American Medical Association Chapter Presidents will follow. The President Elect's Address will be a feature of this Session. There will be a special program entitled, "Underground Atlanta," conducted by an official lecturer.

The Second and Final General Session, on Sunday, May 16, at 9:00 a.m., features a religious observance, the Memorial Service and Presentation of the Certificates of Appreciation, the Life and Fifty Year Membership Certificates and the Distinguished Service Award. The drawing of the name of the winner of the Commercial Exhibits Visitation Award will be held. Immediately following the adjournment of the Second Session of the House of Delegates, the Final Session will reconvene for the Installation of Officers and Adjournment of the 117th Annual Session.

General Meetings

On Friday afternoon an "America—Health Care" panel, featuring Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare; Mr. Robert J. Myers, Former Chief Actuary of the Social Security Administration and now Actuarial Consultant to the American Medical Association; and Mr. Wilbur J. Cohen, Former Secretary of HEW and now Dean of the School of Education, University of Michigan, will be presented. On Saturday the "America—The Drug Scene" panel

will be composed of Dr. Milton Helpert, Chief Medical Examiner, City of New York; Dr. Donald B. Louria, Professor and Chairman, Department of Public Health and Preventive Medicine, New Jersey College of Medicine; and Mr. Domingo Garcia, Director, Youth Challenge Training Center, and Lecturer from South Carolina.

Registration

A general registration desk for all participants will be open in the Marriott Motor Hotel on Thursday, May 13, from 8:30 a.m. to 5:00 p.m.; on Friday and Saturday, from 8:00 a.m. to 5:00 p.m.; and on Sunday, from 8:00 a.m. to 12:00 noon. Admissions to meetings and exhibits will be by registration badge only.

Council

The MAG Executive Committee of Council will meet at 10:00 a.m. on Wednesday, May 12, in Tara Salon 1, Marriott Motor Hotel, and the Council meeting is scheduled for 2:00 p.m., in the same room, on May 12. There will also be an Organizational Council Meeting held immediately following the adjournment of the Annual Session on Sunday, May 16, in the Ballroom.

Reference Committees

All members are invited to appear before the Reference Committees of the House of Delegates on any business being considered by the House. Reference Committees will meet from 9:00 a.m. to 12:00 noon, Saturday, May 15, in assigned rooms at the Marriott Motor Hotel.

House of Delegates

The First Session of the House of Delegates will convene on Friday, May 14, at 9:00 a.m., in the Ballroom of the Marriott Motor Hotel, immediately following the First General Session, at which time nominations of MAG Officers will be made. The Second Meeting of the House will be convened on Sunday, May 16, in the same location, at 9:00 a.m. The Reference Committee

reports will be heard with resultant House actions and voting for MAG Officers will take place by ballot.

Special Feature

A special feature at noon on Friday, May 14, will be Dr. William Y. Rial, AMA Delegate, from Swarthmore, Pennsylvania, who will speak on "The Care and Nurture of the Physician." All of these meetings will be held in the Ballroom of the Marriott Motor Hotel.

Fifty Year and Life Members

Physicians to be awarded Life Membership, and those who have practiced medicine for 50 years will be honored at the Second General Session, Sunday, May 16, at 9:00 a.m., in the Ballroom of the Marriott Motor Hotel.

Life Members

George H. Alexander	Forsyth
C. H. Bryant	Comer
V. L. Bryant	Wadley
W. W. Chrisman	Macon
O. D. Gilliam	Columbus
Guy C. Hewell	Atlanta
J. H. Kite	Atlanta
H. G. Mosley	Atlanta
E. K. Mann	Columbus
B. L. Shackelford	Atlanta
H. F. Sharpley, Jr.	Savannah
Raymond Suarez	Macon

50 Year Members

James F. Adams, Sr., Montezuma
Wallace L. Bazemore, 195 Beverly Pl., Macon
John C. Blalock, 384 Peachtree St., N.E., Atlanta
P. O. Chaudron, Box 227, Cedartown
Herbert M. Edge, Box 188, Blairsville
Charles W. Harwell, Box 644, Moultrie
William F. Jenkins, 1444 Fourth Ave., Columbus
F. Lansing Lee, 1433 Gwinnett St., Augusta
John M. Monfort, Hilton Head, S.C.
Julian K. Quattlebaum, 3710 Waters Ave., Savannah
James W. Reid, 206 S. Broad St., Thomasville
Harry W. Ridley, Box 647, Sea Island
Bernard L. Shackelford, 340 Blvd., N.E., Atlanta
Warner L. Thomason, 729 Piedmont Rd., N.E., Atlanta

Memorial Service

The Association will hold its traditional annual Memorial Service at the Second General Session on Sunday morning, May 16, 9:00 a.m., in the Ballroom of the Marriott Motor Hotel. The event will honor and recall the service and contributions of those deceased members in the past year.

Deceased Members

Charles G. Boland, Sr., Atlanta, January 7, 1971
J. B. Brown, Baxley, August 30, 1970
Taylor S. Burgess, Atlanta, October 9, 1970
John F. Busch, Marietta, May 6, 1970
Howard L. Cheshire, Thomasville, January 7, 1971
E. S. Colvin, Atlanta, February 27, 1971
Leo P. Daly, Atlanta, February 6, 1971
Ben E. Daniel, Jacksonville, Florida, July 13, 1970
Harold L. Dillon, Atlanta, November 5, 1970
Frank L. Eskridge, Jr., W. Panama City, Florida, October 4, 1970
T. J. Ferrell, Waycross, May 29, 1970
Roy L. Gibson, Columbus, February 19, 1971
Louie H. Griffin, Sr., Claxton, January 10, 1971
E. R. Harris, Winder, September 3, 1969
S. P. Holland, Blakely
Anne Hopkins, Savannah, August 31, 1970
C. S. Jernigan, Sparta

Robert W. Johnson, Boston, July 14, 1970
Clarence L. Laws, Atlanta, November 16, 1970
E. A. Lessem, Decatur, June 7, 1970
Malcolm D. Lockhart, Ellenwood, December 23, 1970
Ralph B. McCord, Rome, June 24, 1970
C. K. McLaughlin, Macon, June 16, 1970
Bert H. Malone, Brunswick, December 15, 1970
S. L. Morris, Augusta, December 1, 1970
Emory G. Newsome, Sandersville, September 11, 1970
Thomas F. O'Donald, Bainbridge, December 22, 1970
Wyatt B. Pouncey, Dublin, June 11, 1970
Mark P. Pentecost, Sr., Atlanta, October 10, 1970
L. W. Pierce, Waycross, June 28, 1970
Ernest E. Proctor, Jr., Newnan, November 18, 1970
Frank E. Randolph, Augusta, January 29, 1971
C. L. Ridley, Sr., Macon, October 4, 1970
Jacob Rubin, Savannah, November 25, 1970
William Vernon Skiles, Atlanta, July 3, 1970
John B. Thompson, Columbus, July 6, 1970
O. R. Thompson, Macon
C. M. Warnock, Atlanta, July 23, 1970
Hiram J. Williams, Cordele, January 28, 1971

MAG Message Center

A message center will be maintained near the MAG Official Registration Desk for the convenience of the membership. Messengers from the Woman's Auxiliary will staff this center during the entire session for incoming messages only. A bulletin board at this message center will be available for notices of special importance during the Annual Session.

MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office in the Marriott, in the Wren's Nest Suite.
A MAG Press Room will be available in the Wren's Nest Suite for newspaper, radio and TV personnel.

Hotel Reservations

Officers, Councilors, special out-of-state guest speakers, and Delegates to the MAG House of Delegates will be housed in a reserved block of rooms at the Marriott Motor Hotel. Special reservation forms will be issued to the above by the MAG Office. All of the members will be housed at the Marriott on a first come-first served basis by requesting desired accommodations direct to the Marriott on the form published in the *Journal-MAG* for this purpose.

Elections

The nominations of Officers of the Association, AMA Delegates and Alternates, as well as the election of the General Practitioner of the Year, will be the order of business in the First Session of the House of Delegates, on Friday, May 14. Delegates at the Second Session of the House, on Sunday, May 16, will elect the Officers, AMA Delegates and Alternates, with installation at the Final General Session immediately following the adjournment of the House of Delegates. The Delegates Handbook will list the position vacancies.

Specialty Society Meetings and Social Events

The specialty societies have planned meetings, luncheons and dinners for the membership of their organizations, to be held in conjunction with the Annual Session. These events are listed in the Official Program under "Specialty Society Meetings and Social Events" with the date and time of the event.

Fulton County Medical Society Social Hour

The host society invites the membership and their wives to be their guests for cocktails on Saturday evening, May 15, from 6:30 p.m. to 7:30 p.m., preceding the Annual Banquet. The affair will be held in the Ballroom of the Marriott Motor Hotel. The sponsor will be the Fulton National Bank of Atlanta.

Annual Banquet

The Association will honor its President at the traditional Annual Banquet to be held Saturday evening, May 15, at 8:00 p.m., immediately following the Fulton County Medical Society Social Hour, in the Ballroom of the Marriott. The Incoming President is installed, Awards bestowed, and outstanding entertainment planned at this Banquet. This year the Green County Singing Doctors from Missouri will hold your attention in a "Peer Review." The Hardman and Civic Endeavor Awards will be made at this time, and the Scientific Exhibit and Special Activities Awards will be presented. Prizes for the Art Show Exhibits are given at the Banquet also.

Alumni Events

The Alumni Receptions and Dinners of the two Georgia medical schools, as well as other medical alumni, will be held on Friday evening, May 14. These are listed in the Program under the heading of Alumni Events.

Athletic Events

The Annual MAG Golf Tournament will be held at the Atlanta Country Club (Official Home of the Atlanta Classic) on Friday, May 14, and Dr. Edward J. Waits will serve as Chairman. No official handicap will be requested for entry and contestants may form their own foursomes or singles or twosomes will be placed together. Prizes will be awarded for low net, low gross (Calloway System), close up on par 3's, longest drive, fewest putts, etc. A Social held following the tournament will be arranged. Bring your golf clubs and join the fun.

The tennis tournament will be held on Thursday, May 13, at the Bitsy Grant Tennis Center. Dr. Neal H. Newsom will serve as Chairman.

Further details concerning these tournaments will be published in the official program.

Art Show and Lecture

Each year the art show improves with more participation and interest in all categories. Something new has been added for 1971 in the form of a lecture by the Chairman of the Art Show, on "The Artist in the Twentieth Century." This lecture will be held on Wednesday evening, May 12, at a time and location to be announced in the Official Program, and is open to all who are interested. The exhibits will be on display in Exhibition Hall of the Marriott. Prizes will be given for the First, Second, Third and Honorable Mention places in the show. Mrs. Pano Lamis, Atlanta, is Chairman this year and you may contact her if you have an entry.

GaMPAC

The Georgia Medical Political Action Committee will hold a Breakfast for the Board of Directors at the Marriott, in the Twelve Oaks Suite, on Friday, May 14.

Closed Circuit TV

Plans are progressing for closed-circuit television on current developments in medicine for viewing during hours arranged not to conflict with other activities. Video-taped programming would be received in all rooms at the Marriott. The Program Fare provided will be selected from topics presented at recent AMA meetings. MAG members may be among the first to view these programs.

Scientific Exhibits

Scientific Exhibits will be displayed in the Exhibition Hall of the Marriott, adjacent to the Commercial Exhibits Area. These are prepared by physicians who will be present to discuss their exhibits with the membership. Awards for outstanding research will be presented at the Annual Banquet.

Commercial Exhibits

Approximately 50 Commercial Exhibits will be displayed in the Exhibition Hall. The Exhibition Hall has been floor-planned by the decorating company with new ideas offered in the booth arrangements this year. Your visitation to the Commercial and Scientific Exhibits is important and another handsome prize will be offered this year. The Commercial Exhibitors play an extremely important role in making the Annual Session possible through their support of the meeting.

Commercial Exhibitors

<i>Booth No.</i>	<i>Name of Firm</i>
1	Coca-Cola USA, Atlanta, Georgia
2	Office Communications, Inc., Atlanta, Georgia
3	Charles Pfizer and Company, Inc., Chamblee, Georgia
4	A. H. Robins Company, Richmond, Virginia
7	Ortho Pharmaceutical Corporation, Raritan, New Jersey
8	Pitney-Bowes, Inc., Atlanta, Georgia
9	Parke, Davis & Company, Detroit, Michigan
10	Marion Laboratories, Kansas City, Missouri
11	Sandoz Pharmaceuticals, Hanover, New Jersey
12	Cooper Laboratories, Bedford Hills, New York
13	Reed & Carnrick Pharmaceuticals, Kenilworth, New Jersey
14	Encyclopaedia Britannica, Inc., Chicago, Illinois
15	CIBA Pharmaceutical Company, Atlanta, Georgia
16	G. D. Serle & Company, Chicago, Illinois
17	OTC Professional Appliances, Atlanta, Georgia
24	Bristol Laboratories, Syracuse, New York
25	TAB Products Company, Atlanta, Georgia
28	Imperial Fashions, Los Angeles, California
31	Merrill Lynch, Pierce, Fenner & Smith, Atlanta, Georgia
32	W. B. Saunders Company, Philadelphia, Pennsylvania
33	Warner-Chilcott Laboratories, Morris Plains, New Jersey
34	Medco Products, Atlanta, Georgia
40	C & S Bank Medical Accounting Service, Atlanta, Georgia
41	Stuart Pharmaceuticals, Div. Atlas Chem. Ind., Inc., Pasadena, Calif.
48	S. J. Tutag & Company, Detroit, Michigan
49	Astra Pharmaceutical Products, Inc., Worcester, Mass.
50	Physicians Service, Inc., Columbus, Georgia
51	Ayerst Laboratories, New York, New York
52	Smith, Miller & Patch, Inc., New York, New York
53	Stansell's Oxygen Service, Inc., Atlanta, Georgia
54	Mead Johnson Laboratories, Atlanta, Georgia
55	William P. Poythress & Co., Inc., Richmond, Virginia

Commercial Contributions

Eli Lilly and Company, Indianapolis, Indiana
Roche Laboratories, Nutley, New Jersey
Wyeth Laboratories, Atlanta, Georgia

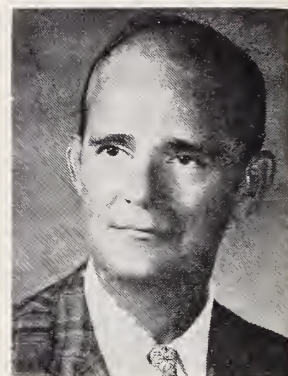
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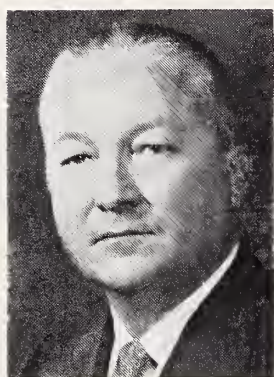
F. G. Eldridge
President



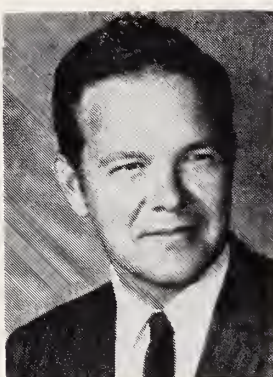
W. C. Mitchell
President-Elect



F. W. Dowda
First Vice President



Henry D. Scoggins
Second Vice President



John Rhodes Haverty
Secretary



C. E. Bohler
Chairman of Council

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Second Vice President—Henry D. Scoggins, Augusta (1971)*
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Vice Speaker of the House—Preston D. Ellington, Augusta (1971)
Editor, JMAG—Edgar Woody, Jr., Atlanta (1971)

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District:

1—C. E. Bohler, Brooklet (1973)
 2—J. D. Bateman, Albany (1973)
 3—J. T. Christmas, Vienna (1973)
 6—Norman P. Gardner, Thomaston (1971)
 7—David A. Wells, Dalton (1971)
 8—Robert E. Perry, Jr., Brunswick (1971)
 9—Paul T. Scoggins, Commerce (1972)
 10—Edwin W. Allen, Jr., Milledgeville (1972)
 Bibb County Medical Society
 Braswell E. Collins, Macon (1972)*

Cobb County Medical Society
 W. C. Mitchell, Smyrna (1972)
 DeKalb County Medical Society
 M. Freeman Simmons, Decatur (1972)
 Fulton County Medical Society
 Fleming L. Jolley, Atlanta (1972)
 John T. Godwin, Atlanta (1971)
 J. Harold Harrison, Atlanta (1973)
 Georgia Medical Society
 L. R. Lanier, Jr., Savannah (1973)
 Muscogee County Medical Society
 Roy L. Gibson, Columbus (1971)
 Richmond County Medical Society
 J. L. Mulherin, Augusta (1972)

* Executive Committee

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District:

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 2—Donald J. McKenzie, Thomasville (1973)
 3—John H. Robinson, Americus (1973)
 6—W. E. Barron, Newnan (1971)
 7—Don Schmidt, Cedartown (1971)
 8—Joe C. Stubbs, Valdosta (1971)
 9—Robert S. Tether, Gainesville (1972)
 10—M. A. Hubert, Athens (1972)
 Bibb County Medical Society
 Milton I. Johnson, Macon (1972)
 Cobb County Medical Society
 Remer Y. Clark, Jr., Marietta (1972)

DeKalb County Medical Society
 Timothy Harden, Jr., Decatur (1972)
 Fulton County Medical Society
 T. J. Anderson, Jr., Atlanta (1972)
 J. Norman Berry, Sandy Springs (1971)
 W. W. Moore, Jr., Atlanta (1973)
 Georgia Medical Society
 L. S. Bodziner, Savannah (1973)
 Muscogee County Medical Society
 Louis A. Hazouri, Columbus (1971)
 Richmond County Medical Society
 Ronald F. Galloway, Augusta (1972)

DELEGATES TO AMA AS OF JANUARY 1, 1971	
Delegates	Term Ending
J. W. Chambers, LaGrange	(12-31-71)
John S. Atwater, Atlanta	(12-31-71)
J. Frank Walker, Atlanta	(12-31-72)
Preston D. Ellington, Augusta	(12-31-72)
Alternate Delegates	
Neal F. Yeomans, Waycross	(12-31-71)
Henry S. Jennings, Gainesville	(12-31-71)
J. D. Bateman, Albany	(12-31-72)
F. W. Dowda, Atlanta	(12-31-72)

A RUBELLA TARANTELLA*

Edgar K. Marcuse, M.D.†

Dorland,¹ Stedman,² Funk and Wagnall,³
 Experts in matters lexicographical;
 Sources of truth, ever close at hand,
 Trusted by editors 'cross the land.

Rubeola, rubella, measles—alas,
 Medical jargon; literary morass.
 “MEASLES” scream the headlines,
 “Rubella” say the fine lines.

Rubeola (German measles), Measles (rubella),
 Chaos reigns from Bangor to Pocatella!
 Webster,⁴ Tabor,⁵ Barnhart,⁶ and the rest
 Compound confusion as these quotes attest:

Thanks to Doctors Gregg, Parkman and Weller,
 A new vaccine can prevent rubella.
 Now offered in clinics throughout the land,
 Another medical triumph grand.

But parents all across our nation
 Refuse permission for this vaccination.
 Why? “’Cause Johnny’s had his measles shot!”¹¹
 Please let us sever this Gordian knot!

Doctors, nurses, students, teachers,
 Authors, editors, and proofreaders;
 Do not further confuse these ills . . .
 Speak of rubella, not German measills!

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* Submitted as a Letter-to-the-Editor item.
 † Formerly with Center for Disease Control, Atlanta.

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NEW DEVELOPMENTS IN CONTINUING MEDICAL EDUCATION

Nearly 20,000 M.D.s have been honored by the American Medical Association for participation in continuing medical education programs.

The Physician’s Recognition Award, established in 1969, has now been given to 19,338 M.D.s. Qualifiers include 11,304 physicians who were in residency training when they applied and 8,304 doctors engaged in full-time patient care.

The Award is given for a minimum of 150 credit hours of continuing medical education earned over a continuous three year qualifying period. At least 60 credit hours must come from any combination of required education categories.

The current listing of continuing education courses for physicians includes 2,319 courses offered by 611 institutions in 41 states, the District of Columbia and Puerto Rico, a 15 per cent increase in the number of courses offered last year. These courses are listed annually in the *AMA Journal*.

OFFICIAL PROGRAM

THURSDAY, MAY 13

- 8:30 General and Delegates Registration**
Exhibition Hall Entrance, Marriott
- 9:00 View Exhibits**
- 9:00 Specialty Society Meetings and Lunches to**
- 5:00** *(See Specialty Society Meetings and Social Events Section)*
- 6:30 Specialty Society Receptions and Dinners**
(See Specialty Society Meetings and Social Events Section)

FRIDAY, MAY 14

- 8:00 General and Delegates Registration**
Exhibition Hall Entrance, Marriott
- 8:30 View Exhibits**
- 9:00 First General Session**
First Session House of Delegates General Meeting
(All MAG, Auxiliary Members and Guests Invited) *North and Center Ballroom, Marriott*
- Presiding**
F. G. Eldridge, M.D., Valdosta, President, Medical Association of Georgia
- Call to Order**
- Invocation**
Rev. John E. Burciaga, Northwest Unitarian Church, Roswell
- Presentation of Colors**
(To be announced)
- National Anthem and Concert**
(To be announced)
- Welcome**
Robert E. Wells, M.D., Atlanta, President, Fulton County Medical Society
- Greetings**
(To be announced)
- Introduction of Distinguished Guests**
- Special Program: "Underground Atlanta"**
Miss Penny Bank, Atlanta, Lecturer
- Report of Woman's Auxiliary**
Mrs. George W. Statham, Atlanta, President-Elect Woman's Auxiliary to the Medical Association of Georgia
- Report From the Student American Medical Association Chapter Presidents**
Mr. John D. Slade, President, Emory

University School of Medicine SAMA Chapter, Atlanta

Mr. Paul C. Atwater, President, Medical College of Georgia SAMA Chapter, Augusta

President Elect's Address

W. C. Mitchell, M.D., President Elect, Medical Association of Georgia

Announcements

Recess

First Session, House of Delegates

Harrison L. Rogers, M.D., Atlanta, Speaker

Nominations of Officers of MAG, AMA Delegates and Alternates

Election of GP of the Year and Award Presentation

Introduction of Business

Announcements

Recess

12:00 Featured Presentation Presiding

J. W. Chambers, M.D., LaGrange, AMA Delegate

"Care and Nurture of the Physician"

William Y. Rial, M.D., Swarthmore, Pennsylvania, AMA Delegate

12:30 View Exhibits

2:00 General Meeting

(All Physicians, Auxiliary Members and Guests Invited)

North and Center Ballroom, Marriott

"America—Health Care"

Moderator

F. W. Dowda, M.D., Atlanta

Panelists

Roger O. Egeberg, M.D., Washington, D.C.

Mr. Robert J. Myers, Silver Spring, Maryland

Dean Wilbur J. Cohen, Ann Arbor, Michigan

4:00 View Exhibits

6:30 Alumni Receptions and Dinners (See Alumni Events Section)

SATURDAY, MAY 15

8:00 General and Delegates Registration *Exhibition Hall Entrance, Marriott*

8:30 View Exhibits

9:00 Reference Committee Meetings

Marriott Motor Hotel

Reference Committee A:

Stone Mountain Suite

Reference Committee B:

Hickory Hill Suite

Reference Committee C:

Twelve Oaks Suite

Reference Committee D:

Thornwood Suite

Reference Committee E:

Whitehall Suite

2:00 General Meeting

(All Physicians, Auxiliary Members and
Guests Invited)

North and Center Ballroom, Marriott

"America—The Drug Scene"

Moderator

Henry D. Scoggins, M.D., Augusta

Panelists

Milton Helpern, M.D., New York City

Donald B. Louria, M.D., Newark, New
Jersey

Mr. Domingo Garcia, Travelers Rest,
South Carolina

4:00 View Exhibits

**6:30 Fulton County Medical Society Social
Hour**

(All MAG Members, Their Wives and
Exhibitors Invited)

North Ballroom, Marriott

8:00 Annual Banquet

Center and South Ballroom, Marriott

Presiding

F. G. Eldridge, M.D., Valdosta, Presi-
dent, Medical Association of Georgia

Presentation of Awards:

Special Activities Awards: Golf, Tennis
and Art

Scientific Exhibits Awards

Hardman Award

Civic Endeavor Award

**Inauguration of President of the Medi-
cal Association of Georgia**

Entertainment

SUNDAY, MAY 16

8:00 General and Delegates Registration

Exhibition Hall Entrance, Marriott

8:30 View Exhibits

9:00 Second General Session

(All MAG and Auxiliary Members and
Guests Invited)

North and Center Ballroom, Marriott

Presiding

F. G. Eldridge, M.D., Valdosta, Presi-
dent, Medical Association of Georgia

Call to Order

Religious Observance

Rev. Thomas A. Whiting, Peachtree
Road Methodist Church, Atlanta

Memorial Service

Rev. Thomas A. Whiting, Peachtree
Road Methodist Church, Atlanta

**Presentation of Certificates of Appre-
ciation**

John Rhodes Haverty, M.D., Atlanta,
Secretary, Medical Association of
Georgia

**Presentation of Life Membership Cer-
tificates**

Henry D. Scoggins, M.D., Augusta, Sec-
ond Vice President, Medical Associa-
tion of Georgia

**Presentation of 50 Year Membership
Certificates**

F. W. Dowda, M.D., Atlanta, First Vice
President, Medical Association of
Georgia

**Presentation of Distinguished Service
Award**

F. G. Eldridge, M.D., Valdosta, Presi-
dent, Medical Association of Georgia

**Selection of Site for May 1973, 1974,
1975 and 1976 Annual Sessions**

Recess

**Second Session, House of Delegates
Presiding**

Harrison L. Rogers, M.D., Atlanta,
Speaker

**Election of MAG Officers, AMA Dele-
gates and Alternates**

Reference Committee Reports

Announcements

Adjournment of House of Delegates

**Second General Session (Recon-
vened)**

Presiding

F. G. Eldridge, M.D., Valdosta, Presi-
dent, Medical Association of Georgia

Installation of Officers

Announcements

Commercial Exhibit Visitation Drawing

Adjournment of 117th Annual Session

SPECIALTY SOCIETY MEETINGS AND SOCIAL EVENTS

GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Saturday, May 15

- 9:00 Business Meeting and Scientific Meeting
Tara Salon 4, Marriott

Sunday, May 16

- 9:00 Scientific Meeting
Tara Salon 4, Marriott

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS, GEORGIA THORACIC SOCIETY AND GEORGIA TUBERCULOSIS-RESPIRATORY DISEASE ASSOCIATION

Thursday, May 13

- 9:00 Scientific Meeting
Tara Salon 1, Marriott
Moderator: Lois T. Ellison, M.D., Augusta
Dr. John V. Weil, Denver, Colorado: "Oxygen in the Arterial Blood-Measurements and Interpretation"; Dr. Roland H. Ingram, Atlanta, Georgia: "Causes of Arterial Hypoxemia"; Dr. John V. Weil, Denver, Colorado: "Ventilatory and Hematologic Responses to Hypoxemia"; and Dr. A. P. Fishman, Philadelphia, Pennsylvania: "Cardiovascular Responses to Hypoxemia."

- 12:00 Luncheon and Business Meeting
Tara Salon 2, Marriott

- 2:00 Scientific Meeting
Tara Salon 1, Marriott
Moderator: Roland H. Ingram, M.D., Atlanta
Dr. John V. Weil, Denver, Colorado: "Air Travel and Mountain Vacations for the Hypoxemic Patient?"; Dr. G. D. Grossman, Atlanta, Georgia: "Oxygen Therapy-Goals and Methods"; Dr. A. P. Fishman, Philadelphia, Pennsylvania: "Hypoventilation and Use of Mechanical Ventilators"; and Dr. G. Michael Duffell, Atlanta, Georgia: "Complications of Excess Oxygen."

- 6:00 Social Hour
Tara Salon 2, Marriott

GEORGIA SOCIETY OF DERMATOLOGISTS

Friday, May 14

- 8:00 Clinicohistopathologic Conference
Pathology Department, Grady Memorial Hospital
Dr. Nardo Zaias, Miami, Florida

- 10:00 Rounds
Grady Memorial Hospital
Dr. Alexander A. Fisher, Woodside, Long Island
7:00 Social Hour and Banquet
Underground Atlanta, "Gone with the Wits"

Saturday, May 15

- 9:00 Scientific Meeting
Hermitage Suite West, Marriott
Presiding: Chenault W. Hailey, M.D., Atlanta; Paul C. Cronce, M.D., Atlanta
Dr. Alexander A. Fisher, Woodside, Long Island; Dr. Nardo Zaias, Miami, Florida; Drs. Algie C. Brown, Atlanta and Robert M. Fine, Atlanta, will be the speakers.
12:00 Business Meeting
Hermitage Suite West, Marriott

Sunday, May 16

- 9:00 Examination of Cases
Fourth Floor, Emory University Clinic
10:00 Discussion of Cases
Emory University Clinic Auditorium
1:00 Luncheon
Tara Salon 3, Marriott

GEORGIA DIABETES ASSOCIATION

Thursday, May 13

- 11:30 Business Meeting
Tara Salon 4, Marriott
Presiding: A. Park McGinty, M.D., Atlanta, Georgia
12:30 Luncheon
(In conjunction with the Georgia Chapter, American College of Physicians and Georgia Society of Internal Medicine)
Tara Salon 4, Marriott
2:00 Scientific Meeting
(In conjunction with the Georgia Chapter, American College of Physicians, Georgia Society of Internal Medicine, Georgia Heart Association, and Georgia Chapter, American College of Surgeons)
North and Center Ballroom, Marriott
2:00 Dr. John A. Owen, Charlottesville, Virginia: "Oral Hypoglycemic Agents-Where Do We Go From Here?"
3:00 Medical Care Foundations
(To be announced)
4:00 Dr. Richard Freyberg, New York (Georgia Arthritis Foundation Speaker): "Current Concepts In the Treatment of Rheumatoid Arthritis."
4:30 Dr. Arnold Fiedotin, Atlanta: "Coronary Cinearteriography."

GEORGIA SOCIETY OF INTERNAL MEDICINE

Thursday, May 13

- 11:30 Business Meeting
Whitehall Suite, Marriott
- 12:30 Luncheon
(With Georgia Diabetes Association and
Georgia Chapter, American College of
Physicians)
Tara Salon 4, Marriott
- 2:00 Scientific Meeting
(With Georgia Diabetes Association, Georgia
Chapter, American College of Physi-
cians, Georgia Heart Association, and
Georgia Chapter, American College of
Surgeons)
Center and North Ballroom, Marriott
(See Georgia Diabetes Association Program)

GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Thursday, May 13

- 12:30 Luncheon
(With Georgia Diabetes Association, Georgia
Society of Internal Medicine)
Tara Salon 4, Marriott
- 2:00 Scientific Meeting
(With Georgia Society of Internal Medicine,
Georgia Diabetes Association, Georgia
Heart Association, and Georgia Chapter,
American College of Surgeons)
Center and North Ballroom, Marriott
(See Georgia Diabetes Association Program)

GEORGIA NEUROSURGICAL SOCIETY

Sunday, May 16

- 12:30 Luncheon
Stone Mountain Suite, Marriott
- 2:00 Scientific Meeting
Stone Mountain Suite, Marriott
Presiding: Charles Dowman, M.D., Atlanta,
Georgia
Dr. Charles Dowman, Atlanta: "Giant Aneurysms"; Dr. Mark S. O'Brien, Atlanta: "Intracranial Surgery for Trauma in a Hemophiliac Child"; Dr. Louis A. Hazouri, Columbus: "Experience with Angiograms and Pneumoencephalograms Over a Ten Year Period"; Drs. R. B. McAdam and T. F. McDonald, Augusta: "Ultrastructural Changes in the Trigeminal Ganglia Following Cadmium Chloride Injury"; Drs. M. A. Cowan and Marshall Allen, Augusta: "The Retrograde Venous Catheter as a Complication of Ventriculoatrial Shunts in Adults"; Drs. T. El Gammal and Marshall Allen, Augusta: "The Intracellular Subarachnoid Reccess: Some Clinical and Radiological Observations"; Drs. John Reynolds, III and Marshall Allen, Augusta: "Intracranial

Suppuration: A Review of 13 Cases"; and Dr. Richard A. Smith, Atlanta: "Cervical Percutaneous Cordotomy"; and Dr. Homer Swanson, Atlanta: "Torkildsen Shunt Procedure"; Dr. Ernest C. Fokes, Jr., Decatur: "Malignant Glioma of the Spinal Cord."

- 6:00 Social Hour
Hickory Hill Suite, Marriott

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Thursday, May 13

- 2:30 Scientific Meeting
(With Georgia Chapter, American Association
of Health Physicians)
Hermitage Suite, Marriott
- 2:30 "Georgia's New Birth Certificate Forms"
(Speaker to be announced)
- 2:45 Questions and Answers
- 2:50 "Genetics in Obstetric Practice"
Moderator: Malcolm G. Freeman, M.D., Atlanta
Dr. Cecil Jacobson, Washington, D.C.: "Clinical Experience in Prenatal Screening of 400 Pregnancies"; Dr. Lewis J. Elsas, Atlanta: "Perinatal Diagnosis of Inborn Errors of Metabolism"; and Dr. William Flynt, Atlanta: "Congenital Malformations in a Metropolitan Community."
- 6:30 Social Hour and Banquet
(With Georgia Chapter, American Association
of Public Health Physicians)
South Ballroom, Marriott

GEORGIA SOCIETY OF OPHTHALMOLOGY

Saturday, May 15

- 9:00 Scientific Meeting
Tara Salon 3, Marriott
- 12:00 Luncheon and Business Meeting
Tara Salon 3, Marriott

GEORGIA SOCIETY OF OTOLARYNGOLOGY

Saturday, May 15

- 9:00 Scientific Meeting
Hermitage Suite, Central, Marriott
(Papers to be presented by Residents of Emory University School of Medicine, University of Alabama and the University of Florida)
- 1:00 Luncheon
Hermitage Suite, East, Marriott

GEORGIA ORTHOPEDIC SOCIETY

Thursday, May 13

- 2:00 Scientific Meeting
Stone Mountain Suite, Marriott
Presiding: R. T. Willingham, M.D., Atlanta

Dr. James M. Alday, Atlanta: "Treatment of Tenosynovitis"; Dr. Hugh Thompson, East Point: "Review of Surgery of 150 Lumbar Discs"; Dr. Ray Jacobs, Augusta: "Experience With Posterior Lateral Back Fusions."

6:30 Social Hour
Hickory Hill Suite, Marriott

GEORGIA ASSOCIATION OF PATHOLOGISTS

Thursday, May 13

2:00 Business Meeting
Twelve Oaks Suite, Marriott
4:00 Scientific Meeting
Twelve Oaks Suite, Marriott
Presiding: Hans Peters, M.D., Columbus
Dr. Milton Helpert, New York City: "The Responsibility of the Forensic Pathologist."
6:30 Social Hour
Plantation Suite A, Marriott
8:00 Dinner
Plantation Suite B, Marriott

GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

Thursday, May 13

2:30 Scientific Meeting
(With the Georgia State Obstetrical and Gynecological Society)
Hermitage Suite, Marriott
5:00 Business Meeting
Hermitage Suite, West, Marriott
6:30 Social Hour and Banquet
(With the Georgia State Obstetrical and Gynecological Society)
South Ballroom, Marriott

GEORGIA RADIOLOGICAL SOCIETY

Saturday, May 15

10:00 Business Meeting
Tara Salon 1, Marriott
12:00 Luncheon
Tara Salon 2, Marriott
2:00 Scientific Meeting
Tara Salon 1, Marriott
Presiding: J. Dudley King, M.D., Atlanta
Dr. James Askew, Atlanta: "Massive Pulmonary Infarction, Unusual Clinical and Radiological Presentation"; Dr. Manuel Viamonte, Jr., Miami, Florida: "Kidney Neoplasias and Pseudoneoplasias"; Dr. Joel Copeland, Atlanta: "Sclerosing Cholangitis"; Dr. Manuel Viamonte, Jr., Miami, Florida: "Radiology of Abdominal Pain and G. I. Bleeding"; and Dr. Rex Teeslink, Augusta: "Potpourri of Special Procedures."
3:45 Film Interpretation Session
Moderator: James V. Rogers, Jr., M.D., Atlanta

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Thursday, May 13

12:00 Luncheon and Scientific Meeting
Tara Salon 3, Marriott
"How I Do It" Clinic
3:00 Scientific Meeting: "The Medical Foundation"
(With Georgia Society of Internal Medicine, Georgia Diabetes Association, Georgia Chapter, American College of Physicians, and Georgia Heart Association)
North and Center Ballroom, Marriott
(See Georgia Diabetes Association program)

ALUMNI EVENTS

MEDICAL COLLEGE OF GEORGIA ALUMNI BOARD OF DIRECTORS

Friday, May 14

12:30 Luncheon
Hickory Hill Suite, Marriott

MEDICAL COLLEGE OF GEORGIA ALUMNI

Friday, May 14

6:30 Reception and Dinner
South Ballroom, Marriott

EMORY UNIVERSITY SCHOOL OF MEDICINE ALUMNI

Friday, May 14

6:30 Reception and Dinner
North Ballroom, Marriott

TULANE UNIVERSITY MEDICAL ALUMNI

Friday, May 14

6:30 Reception
Whitehall Suite, Marriott

EMORY UNIVERSITY SCHOOL OF MEDICINE CLASS OF 1956—15TH REUNION

Saturday, May 15

6:30 Reception
Plantation Suite, Marriott

OTHER EVENTS

GEORGIA MEDICAL POLITICAL ACTION COMMITTEE BOARD OF DIRECTORS MEETING

Friday, May 14

7:30 Breakfast and Meeting
Twelve Oaks Suite, Marriott

Woman's Auxiliary to the Medical Association of Georgia 46th Annual Convention



WELCOME TO ATLANTA

WELCOME TO ATLANTA! We, the Woman's Auxiliary to the Fulton County Medical Society, have been anticipating your visit with much enthusiasm and extend to you a sincere invitation to join us in enjoying a few days in our lovely city for the 46th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia

Your welcome comes threefold and Fulton County wishes to thank DeKalb and Cobb County Auxiliaries for helping us bring to you four days packed full of fun, fellowship and action.

THANK YOU! For the privilege and opportunity to share with you the excitement of the Convention as well as the exchange of ideas, goals, and information gained from the convention program and enthusiasm engendered by association with our State leaders and other auxiliary members.

It is indeed our pleasure to welcome you and we look forward to knowing each person present.

"Come—let us make merry, for in such a way true friendships flourish!"

Mrs. Milton B. Satcher, *President*
Woman's Auxiliary to the Fulton County
Medical Society



PRESIDENT'S GREETING

IT IS TRULY A GREAT PLEASURE and privilege for me as your President to welcome you to our 46th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Atlanta, our Convention City, is an exciting place to be. I should like to thank our members who have been hard at work for months preparing a "Red Carpet" event.

It is my hope and theirs that each of us will remember this convention for its spirit of fellowship, its pride in past accomplishments and for its inspiration for the future.

Sincerely,
Mrs. Charles R. Smith, *President*
Woman's Auxiliary to the
Medical Association of Georgia

THE PROGRAM

THURSDAY, MAY 13

- 9:00 Registration and Information**
to *Convention Floor Lobby*
5:00 *Marriott Motor Hotel*
- 10:00 Hospitality and Exhibits Room**
to *Tara Salon 5*
5:00 *Marriott Motor Hotel*
- 2:00 Pre-Convention Executive Board Meeting**
to *Hickory Hill Suite*
5:00 *Marriott Motor Hotel*
- PRESIDING—MRS. CHARLES R. SMITH, Columbus, *President, Woman's Auxiliary to the MAG*
- INVOCATION—MRS. EDWIN W. ALLEN, Milledgeville, *President, Baldwin County Medical Society*
- PLEDGE OF ALLEGIANCE TO FLAG—MRS. JAMES H. MANNING, Marietta, *Revisions Committee Co-Chairman*
- PLEDGE OF LOYALTY AND COLLECT—MRS. STEPHEN MULHERIN, Augusta, *Tenth District Councilor*
- INTRODUCTION OF PAST PRESIDENTS AND GUESTS—MRS. HAYWARD S. PHILLIPS, Augusta, *Past State President and Councilor to the Southern Medical Association*
- 5:00 Adjournment**
- Eve- ning MAG Specialty Society Receptions and Dinners**
(See MAG Program)

FRIDAY, MAY 14

- 8:00 Registration and Information**
to *Convention Floor Lobby*
5:00 *Marriott Motor Hotel*
- 8:00 Hospitality and Exhibits Room**
to *Tara Salon 5*
5:00 *Marriott Motor Hotel*
- 9:00 MAG General Business Session**
to *Ballroom*
10:00 *Marriott Motor Hotel*
(All MAG and Auxiliary Members and Guests Invited)
- PRESIDING—F. G. ELDRIDGE, M.D., Valdosta, *President*
- REPORT OF WOMAN'S AUXILIARY TO MAG—MRS. GEORGE W. STATHAM, Atlanta, *President-Elect*

10:00 Auxiliary General Meeting

to *South Ballroom*

12:00 *Marriott Motor Hotel*

10:00 Call to Order

MRS. CHARLES R. SMITH, Columbus, *President*

PLEDGE OF LOYALTY AND COLLECT—MRS. H. CHANDLER WHITE, Macon, *President, Bibb County Medical Auxiliary*

ADDRESS OF WELCOME—MRS. MILTON F. SATCHER, JR., College Park, *President, Fulton County Medical Auxiliary*

RESPONSE TO WELCOME—MRS. WILLIAM M. TAYLOR, Columbus, *President, Muscogee County Medical Auxiliary*

PRESENTATION OF CONVENTION PLANS—MRS. GEORGE M. CALLAWAY, Atlanta, *Convention Chairman*

INTRODUCTION OF PAGES FOR THE DAY—MRS. CHARLES E. BROWN, Atlanta

INTRODUCTION OF PAST PRESIDENTS AND GUESTS—MRS. NORMAN B. PURSLEY, Augusta, *First Vice President*

Business Session

(All reports limited to two minutes)

CONVENTION RULES OF ORDER—MRS. LUTHER H. WOLFF, Columbus, *Parliamentarian*

ROLL CALL AND MINUTES—MRS. JOHN G. BATES, Cuthbert, *Recording Secretary*

TREASURER'S REPORT (Including Auditor's Report)—MRS. HARRY B. O'REAR, Augusta, *Treasurer*

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MAG—S. WILLIAM CLARK, JR., M.D., Waycross, *Chairman*

GREETINGS

PRESIDENT OF MAG—F. G. ELDRIDGE, M.D., Valdosta

PRESIDENT-ELECT OF MAG—W. C. MITCHELL, M.D., Smyrna

PRESIDENT'S REPORT—MRS. CHARLES R. SMITH, Columbus

PRESIDENT-ELECT'S REPORT—MRS. GEORGE W. STATHAM, Atlanta

ADDENDUM REPORTS—State Officers and Chairmen (Complete reports are

published in the 1970-1971 Annual Report Book)

RECOMMENDATIONS FROM THE EXECUTIVE BOARD—MRS. JOHN G. BATES, Cuthbert

REPORT OF THE REVISIONS COMMITTEE—MRS. JAMES H. MANNING, Marietta, *Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. STANLEY GREGOROFF, Atlanta, *Chairman*

11:00 Introduction of Guest Speaker

MRS. S. WILLIAM CLARK, JR., Waycross, *Immediate Past President*

ADDRESS—MRS. AMOS N. JOHNSON, *Southern Regional Vice President, Woman's Auxiliary to the AMA, Garland, North Carolina*

ANNOUNCEMENTS

12:00 Recess of Session

12:00 MAG Featured Speaker

"The Care and Nurture of the Physician"—WILLIAM RIAL, M.D., *AMA Delegate, Swarthmore, Pennsylvania*

(All MAG and Auxiliary Members and Guests Invited)

North and Center Ballroom, Marriott Motor Hotel

12:30 Luncheon

to (For Members and Guests)

2:00 *Hermitage Suite*

Marriott Motor Hotel

PRESIDING—MRS. CHARLES R. SMITH, Columbus, *President*

INVOCATION—MRS. A. WORTH HOBBY, Atlanta, *Past President*

INTRODUCTION OF PAST PRESIDENTS—MRS. J. R. S. MAYS, Macon, *Past President*

2:00 Tour of Underground Atlanta, to High Museum of Art and Ending at Phipps Plaza

Transportation from Cain Street Entrance

Marriott Motor Hotel

Evening Alumni Receptions and Dinners and Other Alumni Functions
(See MAG Program)

SATURDAY, MAY 15

8:00 Registration and Information

to *Convention Floor Lobby*

5:00 *Marriott Motor Hotel*

8:00 Hospitality and Exhibits Room

to *Tara Salon 5*

5:00 *Marriott Motor Hotel*

9:00 Auxiliary General Meeting

to *South Ballroom*

12:00 *Marriott Motor Hotel*

Call to Order

MRS. CHARLES R. SMITH, Columbus, *President*

INVOCATION—MRS. SHELLEY C. DAVIS, Atlanta, *Past President*

Introduction of Guest Speaker

MRS. HAYWARD S. PHILLIPS, Augusta, *Councilor to Southern Medical Association*

ADDRESS—MRS. RAMSEY H. MOORE, *President, Woman's Auxiliary to the Southern Medical Association, Dallas, Texas*

PLEDGE OF ALLEGIANCE TO FLAG

—MRS. DON T. SMITH, Tifton, *President Tift County Auxiliary*

PLEDGE OF LOYALTY AND COLLECT—MRS. ALVAH J. NELSON, LaGrange, *President, Troup-Heard County Medical Auxiliary*

INTRODUCTION OF PAGES FOR THE DAY—MRS. CHARLES E. BROWN, Atlanta

INTRODUCTION OF PAST PRESIDENTS—MRS. WALKER L. CURTIS, College Park, *Past President*

CONVENTION ANNOUNCEMENTS—MRS. HOWARD S. BROWN, Atlanta, *Convention Co-Chairman*

MEMORIAL SERVICE—MRS. W. H. BENSON, JR., Marietta, *Cobb County Medical Auxiliary*

MRS. JAMES H. MANNING, Marietta, *Cobb County Medical Auxiliary*

Business Session

MINUTES—MRS. JOHN G. BATES, Cuthbert, *Recording Secretary*

REPORT OF THE REVISIONS COMMITTEE—MRS. JAMES H. MANNING, Marietta, *Cobb County Medical Auxiliary, Chairman*

REPORT OF THE BUDGET AND FINANCE COMMITTEE—MRS. GEORGE HARRISON, Marietta, *Cobb County Medical Auxiliary, Chairman*

REPORT OF THE RESOLUTIONS COMMITTEE—MRS. HARRY BROWN, *President, Peach Belt Medical Auxiliary, Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. STANLEY GREGOROFF, Atlanta, *Fulton County Medical Auxiliary, Chairman*

REPORT OF THE COURTESY COMMITTEE—MRS. HERBERT S. HARPER, Augusta, *President, Richmond County Medical Auxiliary, Chairman*

REPORT OF THE AWARDS COMMITTEE—MRS. PAUL J. PAYNE, Marietta, *Cobb County Medical Auxiliary, Chairman*

Achievement—MRS. PAUL J. PAYNE, Marietta, *Chairman*

Health Careers Award—MRS. IVAN LEE PEACOCKE, Decatur, *Chairman*

Safety and Disaster Preparedness—MRS. ROBERT M. FINE, Decatur, *Chairman*

AMA-ERF—MRS. BENJAMIN BASHINSKI, JR., Macon, *Chairman*

Mrs. J. Bonar White Scrapbook—MRS. JAMES H. SULLIVAN, Columbus, *State Scrapbook, Chairman*

James N. Brawner, Sr., M.D., Awards for General Excellence—MRS. S. WILLIAM CLARK, JR., *Past President, Waycross, Chairman*

Doctor's Day—MRS. JACK B. LINDLEY, Augusta, *Chairman*

REPORT OF MAG CONVENTION—PRESTON D. ELLINGTON, M.D., *Chairman, MAG Annual Session Committee*

REPORT OF NOMINATING COMMITTEE—MRS. S. WILLIAM CLARK, JR., *Waycross, Chairman*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—MRS. AMOS N. JOHNSON, *Southern Regional Vice President, Woman's Auxiliary to the American Medical Association, Garland, North Carolina*

INAUGURAL ADDRESS AND ANNOUNCEMENTS OF 1971-1972 STATE CHAIRMEN—MRS. GEORGE W. STATHAM, Atlanta, *President*

PRESENTATION OF PAST PRESIDENT'S PEN—MRS. S. WILLIAM CLARK, JR., *Waycross*

ANNOUNCEMENTS

12:00 Adjournment

12:45 Luncheon
to *Lancaster D Room*

2:00 *Regency Hotel*
(Transportation from Cain Street Entrance of Marriott at 12:30 p.m.)

PRESIDING—MRS. GEORGE W. STATHAM, Atlanta, *President*

INVOCATION—MRS. DAVID L. MORGAN, Decatur, *President, DeKalb County Auxiliary*

12:45 Past Presidents' Luncheon (Dutch)
Dutch Suite

Regency Hotel

(Transportation same as above)

PRESIDING—MRS. S. WILLIAM CLARK, JR., *Waycross, Past President*

2:00 MAG General Meeting

to "America—The Drug Scene"

4:00 *North and Center Ballroom, Marriott*

Panel—DR. MILTON HELPERN, New York;
DR. DONALD B. LOURIA, New Jersey;
MR. DOMINGO GARCIA, South Carolina

6:30 Fulton County Medical Society Social Hour

(All MAG Members, Their Wives and Exhibitors Invited)

North Ballroom

Marriott Motor Hotel

8:00 Annual Banquet

Center and South Ballroom

Marriott Motor Hotel

SUNDAY, MAY 16

8:00 Registration and Information

to *Convention Floor Lobby*

12:00 *Marriott Motor Hotel*

8:00 Hospitality and Exhibits Room

to *Tara Suite 5*

12:00 *Marriott Motor Hotel*

9:00 Post Convention Executive Board Breakfast (Dutch) and School of

12:00 Instruction

Hermitage Suite West

Marriott Motor Hotel

PRESIDING—MRS. GEORGE W. STATHAM, Atlanta, *President*

9:00 MAG Second General Session and Second Session, House of Delegates

12:00
(All MAG and Auxiliary Members and Guests Invited)

Ballroom

Marriott Motor Hotel

PRESENTATION OF AWARDS

ELECTION AND INSTALLATION OF OFFICERS

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA—1970-1971

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Friday Luncheon

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Saturday Luncheon

Mrs. David L. Morgan, Decatur

Past President's Luncheon

Mrs. John T. Leslie, Avondale Estates

Post Convention Breakfast and School of Instruction

Mrs. Garland P. Bennett, Jr., Decatur

President's Banquet

Mrs. John K. Davidson, III, Atlanta

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

CRITERIA FOR SELECTION OF RECIPIENTS OF MAG AWARDS

GENERAL PRACTITIONER OF THE YEAR—

This award is presented to an outstanding General Practitioner in Georgia. Selection of the recipient and presentation of the award will be made by the House of Delegates from ballots cast during the first session of the House. The Georgia Academy of General Practice has been invited to make one or more nominations for this award. No nominations for this award will be considered unless accompanied by the supporting biographical data and received at the Headquarters Office of the Medical Association of Georgia at least two weeks prior to the opening of the Annual Session. No nominations for this award may be made from the Floor of the House of Delegates. The President of the Georgia Academy of General Practice will present this award at the First Session of the House.

HARDMAN CUP—This award is presented for "the achievement of anyone who in the judgement of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented at the Annual Banquet, Saturday evening, May 15. By custom this award has usually gone to a Georgia physician.

However, this is not required by the terms of the letter from Governor Hardman establishing this award.

DISTINGUISHED SERVICE—The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component County Medical Societies and must be received at the MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five man secret committee and presentation will be made on Sunday, May 16, 9:00 a.m., at the final General Session.

CERTIFICATES OF APPRECIATION—Recipients of Certificates of Appreciation will be selected jointly by the MAG Committee on Awards, Executive Committee and Council. These will be presented on Sunday, May 16, at 9:00 a.m., at the final General Session.

CIVIC ENDEAVOR AWARD—This is a new award, presented for the first time at the 1969 Annual Session, and will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component County Medical Societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters Office at least two weeks in advance of the Annual Session. The recipient of this award will be selected by a three man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at the Annual Banquet, Saturday evening, May 15.

Come to Atlanta in May



THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 13, 1971

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 14, 1971

- 9:00 a.m.—First General Session
First Session, House of Delegates
General Meeting
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—Health Care"

- 6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 15, 1971

- 9:00 a.m.—Reference Committee Meetings
- 9:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—The Drug Scene"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 16, 1971

- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia Annual Session

May 13-16, 1971—Atlanta, Georgia
RESERVATION REQUEST

1. Please complete this form and mail directly to: Reservation Department
Marriott Motor Hotel
Courtland and Cain Sts.
Atlanta, Georgia 30303
2. Special reservation cards will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
3. Assignment of rooms will be made in the order of receipt of reservation. If possible, confirmation will be in accordance with preference indicated; if not, best substitute will be made.
4. Unreserved accommodations will be released on May 1, 1971.
5. Rooms will not be ready for occupancy until 2:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.
6. A quick check out card will be placed in each room. Turn this in at Registration Desk and you will be billed later.

DAILY MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Bedroom		Suites	Each Additional Person
1 person	\$22-26	\$35-100	under 12 no charge
2 persons	\$28-32		each additional person over two \$3.00
			roll-away in room \$4.00

ALL RATES PLUS 3% GEORGIA STATE SALES TAX

Cut out and send to the Marriott:

Please type or print

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION
MAY 13-16, 1971

NAME

ADDRESS

CITY & STATE ZIP

ARRIVAL DATE DEPARTURE DATE

TYPE ACCOMMODATIONS DESIRED FOR # OF PERSONS

The hemodynamic effects of this abnormality depend ultimately on the status of the patient at the inception of the arrhythmia.

Hemodynamic Effects of Cardiac Arrhythmias

ALAN G. BARTEL, M.D.,* and HENRY D. McINTOSH, M.D.,† Durham, N.C.

RECENT ADVANCES in intensive cardiac care and widespread use of continuous electrocardiographic monitoring have emphasized the frequency and nature of cardiac rhythm disturbances. Recognition, however, requires at least a consideration of therapy. Proper therapy is predicated on an understanding of the "natural history" and hemodynamic consequence of a specific arrhythmia.

The net effect of a particular arrhythmia is determined by the circulatory state of the patient as well as the nature of the rhythm disturbance. Usually "benign" rhythm disturbances such as bigeminy, atrial fibrillation, etc., occurring in the patient with a limited cardiac reserve, may rapidly result in severe cardiac decompensation with myocardial ischemia, hypoxia, and hypotension, shock, or death. Furthermore, the arrhythmia may compromise the blood supply to the end organs, and thus produce myocardial infarction, renal failure, cerebrovascular accidents, hepatic necrosis, infarction of the intestinal tract, etc.

Since many arrhythmias are transient, and cause only minor alterations of the circulation, or occur in patients with less severely compromised circulations, the symptoms produced may be vague and non-specific. Such symptoms include palpitations, episodes of weakness and fatigue; on the other hand, they may cause more serious symptoms and signs such as transient neurological deficits, lapses of memory, presyncope or syncope, increasing congestive heart failure, increasing angina, intermittent claudication, etc.

It must be remembered that the hemodynamic effects resulting from an arrhythmia are not due

solely to the changes of cardiac function. The observed response of the circulation may well be due to peripheral effects. Thus, the status of the peripheral resistance, blood volume, baroreceptor activity, and venous return must be considered in any critical analysis of arrhythmic effects.

Rather than discussing the hemodynamics of particular arrhythmias, it is useful to consider the physiologic alterations that may be produced by any arrhythmia.

Rate

The rate of contraction of the ventricles will determine the cardiac output if the volume of blood ejected with each stroke remains unchanged. Thus, rapid or slow rates critically affect hemodynamics. Bradycardia may produce profound effects, especially when the stroke volume cannot increase and peripheral compensatory mechanisms are inadequate. In many patients, however, the heart may compensate physiologically during slow heart rates by increasing stroke volume due to increased ventricular filling and ventricular wall pressure (Starling's Law). The net effect of increased stroke volume may compensate for a decreased heart rate resulting in insignificant changes in cardiac output which can be adequately compensated for by an increase in peripheral resistance.

In addition, bradyarrhythmias may permit the discharge of "irritable" pacemaker foci, thus predisposing to tachyarrhythmias and producing bradycardia-tachycardia syndromes.

If the heart rate increases beyond a critical rate (varying with the basic status of the cardiovascular system) the ventricle fills incompletely during diastole, resulting in a decreased output per beat. A similar, but transient, effect occurs during rapid irregular rhythms or multiple premature contractions (the

* Instructor in Medicine.

† Professor of Medicine and Chief, Cardiovascular Division, Cardiovascular Laboratory, Department of Medicine, Duke University Medical Center, Durham, North Carolina.

Prepared by the Georgia Heart Association for this Journal.

earlier the contraction, the smaller the subsequent output).

Atrial Kick

Although appreciated by Harvey (1628), the importance of coordinated contractions of the atria and ventricles and the contribution of atrial systole to ventricular filling have recently been reemphasized. In normal hearts, atrial contraction may add between 10-20 per cent of ventricular volume, whereas in severe valvular heart disease, such as mitral stenosis, the diastolic ventricular volume may increase over 50 per cent during the period of atrial systole. It has been demonstrated that with an effective well-placed atrial contraction a higher ventricular end-diastolic volume may be obtained with a lower mean atrial pressure than occurs when the atria are not functioning properly. Insufficiency of the AV valves may also be produced by the loss of coordinated atrial and ventricular contractions, resulting in detrimental cardiovascular effects.

The hemodynamic effects of a rapid or slow heart beat may be minimal if the "atrial kick" is preserved, but when it is lost, the additional insult may cause decompensation.

Common examples of tachycardia associated with loss of coordinated atrial and ventricular contractions are atrial fibrillation, junctional (nodal) rhythm, and partial (second degree) heart block. The commonly used types of ventricular pacemakers should also be included, since atrial and ventricular contraction are not synchronized.

Method of Ventricular Activation

Several studies have shown that alteration of the normal sequence of activation of ventricular contraction results in adverse hemodynamic effects. Given two arrhythmias with identical coordination of atrial and ventricular contraction and the same heart rate, one demonstrating an abnormal sequence of ventricular activation (i.e., aberrant conduction) and the other normal sequence of activation, the former will result in greater alteration of hemodynamics. Such

alterations, in addition to the absence of an effective atrial kick, explain why ventricular tachycardia or junctional tachycardia with aberrant conduction is less well tolerated than atrial tachycardia. It may also explain why patients with sinus bradycardia may deteriorate rather than improve when the *heart rate* is increased by fixed rate ventricular pacing (loss of atrial kick and normal ventricular activation).

Effects of Pharmacologic Agents

It should be mentioned that in the conversion of arrhythmias, especially tachycardias, to a normal sinus mechanism with drugs, the frequent myocardial depressant effect of these medications may result in a significant, although usually transient, fall in cardiac output. Thus, the administration of drugs such as lidocaine, quinidine, Procainamide (Pronestyl®), Diphenylhydantoin sodium (Dilantin®), and propranolol hydrochloride for management of arrhythmias should be performed under careful monitoring: the smallest effective dose should be used with the expectation that the patient may experience a temporary decrease in cardiac output even after normal rhythm has been established.

Conclusion

The clinical manifestations of cardiac arrhythmias may produce unusual or ill-defined symptom complexes. The occurrence of incipient or increasing congestive heart failure, angina pectoris, intermittent claudication or episodic dizziness, fatigue, transient neurological disturbances or paroxysms of dyspnea should alert the physician to consider the possibility of a cardiac arrhythmia.

It can be concluded that the hemodynamic effects of arrhythmias depend upon the underlying status of the myocardium, blood vessels, and end organs, the heart rate, preservation of the "atrial kick," and normal sequence of activation of the ventricles. The altered hemodynamic effects may be further aggravated by the effects of pharmacologic agents used to correct the arrhythmia.

Duke University

CALL FOR SCIENTIFIC EXHIBITS

117TH ANNUAL SESSION OF THE
MEDICAL ASSOCIATION OF GEORGIA

Atlanta, Georgia, May 13-16, 1971

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman
MAG Scientific Exhibits Committee
938 Peachtree Street, N.E., Atlanta, Georgia 30309

In Georgia, a legal tool has been provided to encourage the finding and identification of children who are being abused and extend to them the right of protection.

Special Article

Protecting the Abused Child in Georgia: Identifying and Reporting

DESBERT J. WHITE, JR.,* ACSW, Atlanta

THE MYRIAD OF SOCIAL PROBLEMS that confront our society today often overtax our resources and elude solutions. Many of these problems are of such magnitude and complexity that often they overshadow areas that affect fewer individuals but, nevertheless, are serious causes of concern. One example is the distressing reality of maltreatment of children or child abuse. Although not affecting a large portion of the population this is an area that has serious implications for many of our children. Further, by including the many more thousands of children suffering from the various other forms of child neglect, the problem increases in scope and significance.

Child abuse presents itself in many forms and is very often difficult to correctly identify. Once discovered, its treatment requires substantial skill, patience, and adequate community resources. The children who suffer the abuse are sometimes malnourished as a result of severe neglect, or may be emotionally damaged by rejecting parents. Others may be physically assaulted by their parents or caretakers and some so severely that the "battered child syndrome"³ has been used to categorize their condition.

Although the incidence of child abuse is not accurately known, a recent educated estimate places the occurrence at more than 10,000 severe cases nationally each year.¹ It is further believed that many more cases exist, but with less serious implications. The increased general knowledge of these abusive situations and the need for finding and identifying other cases has fostered public awareness and concern. Consequently, in recent years all states have enacted various forms of child abuse legislation, creating a

framework for reporting instances of maltreatment and usually requiring mandatory reporting by certain groups, notably physicians. The various laws have also frequently designated certain agencies or organizations as the recipients of the reports and responsible for evaluating the circumstances and protecting the child from further injury.

Abuse in Georgia

There are no available statistics as to the incidence of child abuse in Georgia. Records do indicate that for the years 1967 and 1968 there were 147 *known* and *reported* cases of child abuse. However, based on available information it is assumed that this figure reflected only a portion of the total problem. Presently it is believed that many situations of child abuse are never identified and others are known, but never reported. Even so, the number of children mistreated will be small compared to the total number of children needing and receiving services rendered by various helping agencies, other groups, and individuals. However, because of the reality that child abuse does occur, it gives rise to an area of serious concern. The very nature of the problem creates for children a situation with more hazardous potential than might other circumstances. These children are frequently "locked in" in the setting of abuse because of age, and dependency on those often inflicting the maltreatment. To remain in the situation without changes would be detrimental to their physical and emotional well being, and the resulting consequences for many of these children could be severe injury or even death. It is therefore important that we identify children living in abusive situations and extend to them and their families the services needed to hopefully overcome this potential destructiveness.

* Child Welfare Consultant, Protective Services, State Department of Family and Children Services, Atlanta, Georgia.

In Georgia, a legal tool has been provided to encourage the finding and identification of children who are being abused and extend to them the right of protection. Georgia Annotated Code 74-111, Reports of Cruel Treatment of Children, was enacted in 1965, and provides the framework for reporting situations to a designated agency for the purpose of intervening in cases of abuse.

Specifically, the legislation requires that any “. . . physician . . . , licensed osteopathic physician, intern, resident, dentist, podiatrist, public health nurse, or welfare worker . . .”² shall report or cause a report to be made on any child under 12 years of age. The report would follow after an examination indicated that the child sustained physical injury or injuries inflicted by other than accidental means by a parent or caretaker. If a physician is performing in a hospital or other institution, he shall notify the person in charge of the institution for the implementation of the reporting.

Report Abuse

The law further provides that when abuse is suspected, “. . . an oral report shall be made immediately by telephone or otherwise, and followed by a report in writing to a child welfare agency providing protective services, or in the absence of such agency, to an appropriate police authority.”² In Georgia, the designated child welfare agency which receives and evaluates the reports of abuse is the Department of Family and Children Services located in each county. The report, both oral and written, “. . . shall contain the names and addresses of the child and his

parents or caretakers, if known, the child's age, the nature and extent of the child's injuries . . .”² and any other information that would be helpful in determining the cause of abuse and in identifying the person suspected of the abuse. Including any information as to any previous injuries would also be valuable.

Mandatory reporting is a requirement of the legislation for the groups named in the provisions when child abuse is suspected. However, immunity is granted to “. . . any person or persons, partnership, co-partnership, firm, corporation, association, hospital or other entity participating in the making of said report . . .”² within the provisions of the law. Those reporting are “. . . immune from any liability, civil or criminal, that might otherwise be incurred or imposed . . .”² provided that the report was made in good faith.

One purpose of the legislation of course is to identify those children suffering abuse. However, an important intention is to provide the needed assistance to the children and their families to “. . . prevent further abuses, protect and enhance the welfare of these children, and preserve family life wherever possible.”² Thus the law is non-punitive with an emphasis on helping both the child and parents rather than punishing the person inflicting the injuries. The law recognizes that abuse is rarely willful or deliberate cruelty to a child, but is more frequently a symptom of personality dysfunctioning, that requires help and treatment rather than punishment. Therefore a social agency is designated as the recipient of the report and hopefully will be able

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL JANUARY 17, 1971

Finance: Voted to add \$200 to the budget of the School Child Health Committee.

Recommended to the Committee on Constitution and Bylaws that they prepare an amendment which will require those members removed from the rolls for non-payment of the 1969 additional dues to pay those dues before reinstatement.

Emergency Medical Services: Approved a resolution to the Governor of the State of Georgia prepared by the MAG Committee on Emergency Medical Services, calling for the appointment of a Commission on Emergency Medical Care in Georgia.

Appointments: Approved consultants for Prudential Medicare.

Appointed to the GRMP Regional Advisory Group Don Schmidt, M.D., Cedartown, Seventh District; David Wells, M.D., Dalton, Alternate Seventh District; Joe C. Stubbs, M.D., Valdosta, Eighth District; Robert Perry, M.D., Brunswick, Alternate Eighth District.

Policy Manual on Medical Review and Negotiating:

Approved an addition to the Policy Manual on Surgical Assistants in Ophthalmological Operations to be worded by MAG legal counsel.

Licensure: In light of new information, voted to no longer oppose efforts to abolish the citizenship requirement for medical license in Georgia.

Hospital Employed Unlicensed Physician: Voted to table this matter indefinitely since continued investigation served no one's best interest.

County Boards of Health Expanded Activity: Voted to request the State Department of Health not to introduce proposed legislation expanding the authority of the County Boards of Health and voted to oppose the legislation if introduced.

Board of Medical Examiners: Voted to protest to the Board of Medical Examiners their action suspending a MAG member's license without a hearing.

Next Meeting: Sunday, February 7, Sheraton Biltmore, following adjournment of County Society Officers' Conference.

CHILD ABUSE / White

to employ its own resources and those of the community in treating the problem to prevent further abuse.

Case Evaluation

An evaluation of the circumstances will begin once a report is received by the agency. Using information contained in the initial report and gathering additional data, the agency, perhaps with the assistance of others in the community, will determine if abuse to the child has occurred. If so, appropriate measures would then be formulated to protect the child. Often these steps would require the close involvement with the parents in determining the causes of the abuse and the prevention of its recurrence. Frequently to protect the child, the Juvenile Court will be requested to assist the agency in planning for the family. A decision might be made as to whether or not to leave the child in his own home under court jurisdiction, or to remove him to a foster home or other facility. In the case of removal of the child, the agency would continue its involvement with the parents to assist them in the resolution of the problems that led to the abuse.

The goal in protecting the child is to attempt to secure his adequate care in his own home whenever possible. Even in instances of removal of the child,

the plan remains in many cases as one of eventual reuniting of the family. Exceptions would be those very critical situations in which the pathology of the parents is so severe and treatment unsuccessful that it would be hazardous to consider returning the child.

The task of adequately ensuring the protection of these children is a difficult one with numerous problems still to be solved. Lack of sufficient staffs in the county agencies and limited community resources impede services to the children and their families. Additional knowledge of the causes and implications for treatment of the problem must be acquired, as well as a higher degree of community support for the program and its objectives. Yet, progress will continue to be made through the cooperative efforts of the various professional groups and individuals who frequently are involved in the solution of the physical and social problems of children. However, an alertness to the reality of child abuse and a desire and commitment for adequate services to be provided is not just the responsibility of a profession but one of all citizens.

State Office Building 30334

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AMERICAN INDUSTRIAL HEALTH CONFERENCE

April 19-22, 1971

Marriott Motor Hotel

Atlanta, Georgia

Plan to Attend!

A local attempt to prevent the widespread abuse of drugs among the high school students in the city of Rome, based on establishing dialogue with the students and sharing information about the dangers of drug abuse.

Project D.D.D.

(Dialogue on Drug Dependence)

EDUARDO MONTANA, M.D.,* *Rome*

IT IS A FACT that drug abuse is reaching epidemic proportions in our country. It is also undeniable that the problem exists in the city schools of the State of Georgia as evidenced by the recent interest of state officials in sponsoring programs to control the situation.¹

To my knowledge, there are not valid statistics to estimate the proportions of the drug abuse or the number of addicts in our state. However, information from around the country shows that at least 15 per cent and perhaps as many as 30 per cent of college students are chronic drug users. The numbers of high school "experimenters" seem to be increasing.

Doctors in general, and pediatricians in particular, are frequently called to help in crash programs, panels, and lectures. It is, therefore, our responsibility to become informed about drugs because the prevention of drug abuse touches the very essence of our commitment to the maintenance of health.

Suggested Action

The American Academy of Pediatrics has sounded the alarm asking the local chapters for positive action. The problem was discussed at the recent meeting of the Committee on Youth of the Georgia Chapter.² The following recommendations were issued:

1. To initiate local surveys of youngsters involved in drug experimentation and rates of addiction in the state.
2. To cooperate with other agencies in the study of the syndrome: adolescent unrest, and the symptom: drug abuse.
3. To seek rehabilitation of drug abusers.
4. It was proposed that the committee function as an office for accumulation and dissemination of

informative material to help local doctors and community agencies in the planning of their programs.

In my opinion, these recommendations are sound. Information about the dangers of drug abuse, although incomplete in many areas, is available. My questions are: Is this information reaching the children? If not, who is in the best position to communicate with them, how and when?

So far, in many communities throughout Georgia, the efforts have been directed to better inform parents, in the hope that they in turn become better qualified to help their children. I wonder: Is communication between parent and child open in such a way to effectively share information about drug abuse?

The battle is joined by law enforcement officers, clergymen and teachers. The former, in many situations, are not effective because "In a time when law and order has become an euphemism for repression, the policeman bears a considerable handicap as an educator of the restive young. Furthermore, at least as concerns marijuana, the police are responsible for enforcing laws that many youngsters, including non-users of drugs, consider unjust."³

Clergymen are rarely effective in their isolated attempts. Dr. D. L. Farnsworth, Director of Harvard University Health Services, said recently: "Most clergymen have been unable to take any constructive approach to the problem of drugs. Many already feel out of touch with the younger members of their congregations and are further handicapped by their lack of knowledge about drugs."⁴

Young educators are often in an advantageous position, provided that they have been able to establish a rapport with their students, based on mutual trust and confidence. However, there is an urgent need for seminars and workshops to instruct the new generation of teachers about the psychologic motivations of children and the dangers of drug abuse.

* Dr. Montana is a practicing pediatrician in Rome, Georgia, and a member of the Committee on Youth, Georgia Chapter, American Academy of Pediatrics.

PROJECT / Montana

Multifaceted Problem

The drug abuse problem is a multifaceted one. I don't believe that one entity or individual *alone* can accomplish much. The role of doctors, as I see it, is the one of coordinator of community resources. However, well-informed parents, teachers, clergymen, and doctors working together won't be effective unless the children become strongly motivated to seek help and information. Almost any teacher will tell us that the students seem to be tired of talking about drugs. The epidemic thrives in the midst of the students' apathy. . . .

Children are tired of being *talked to*; they want to *talk with* somebody who'll listen to them and help them find honest answers to their many questions. I submit that we talk less and listen more.

Dr. Roy Menninger wrote recently: "I think we have failed our youth by having failed to listen, or if to listen, failed to hear."⁵

The adults involved in dialogue with adolescents, in my opinion, should avoid appearing as experts. We are to be reminded that we, ourselves, have the obligation to become more and more informed about the problems of youth; that we, ourselves, may have emotional hang-ups, misconceptions, or partial knowledge.

Rome Program

With the above considerations in mind, we have initiated a program in Rome, Georgia. Our ultimate goal is "To help teenagers to help themselves to become physically healthy, emotionally mature, socially adjusted adolescents."⁶

The following steps are in motion:

First: Stimulation of honest, constructive dialogue between selected teachers and small groups

of students in the city schools.

Second: The second component of this program is a consultant group to which students and teachers will refer for information. The consultants are local professionals from various disciplines.

Third: Questions, answers, opinions, and facts resulting from the student-teacher-consultant dialogue will be turned over to a coordination committee, in our case provided by the local Jaycees. This group will raise the funds for the publication of a booklet entitled: D.D.D. (Dialogues on Drug Dependence), to be distributed freely to parents and children.

In summary: We are working on a program for prevention of drug abuse through dialogue to share information. We encourage parents' participation and try to enlist enthusiastic teachers to motivate the students to tackle their own problems. We are trying to put the community resources together, making emphasis on the local character of the effort. We hope that the booklet D.D.D. will be original and informative and will reach a larger audience. We are hoping that this report will stimulate doctors and community agencies to fight together in the battle against drug abuse.

16 Hospital Circle 30161

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1. Governor's Conference on Drug Abuse, Atlanta, Georgia, September 1970.
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3. Vogl, A. J.: Influencing kids against drugs, what works?; *Medical Economics*, Special Issue, April 20, 1970.
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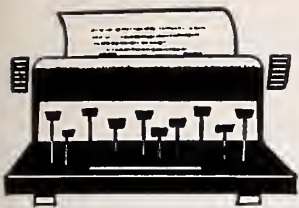
SOCIO-ECONOMIC PROGRAM TO BE PRESENTED

Beginning at 9:15 a.m. on Friday, April 2, 1971, the Georgia Hospital Association will present an outstanding program on the Socio-Economics of Health Care. The meeting to be held in the Sheraton Hall of the Sheraton Biltmore Hotel, Atlanta, will feature a talk entitled "A Plan for Providing and Financing Health Services in the '70's," by Dr. Thomas H. Ainsworth, Jr., Associate Director, American Hospital Association; a talk entitled "Administration's Proposal for Financing Health Services," by a representative of the Department of HEW; a talk entitled "Medicredit

Plan as Proposed by the American Medical Association," by James W. Foristel, Director, Department of Congressional Relations, American Medical Association, Washington, D.C. This section of the GHA program is scheduled for adjournment by noon.

The afternoon session of the GHA meeting of April 2 includes presentations on Comprehensive Prepaid Health Care Plans and the role of physicians' assistants by outstanding experts in those fields.

MAG members are welcome to register and attend all sessions of the GHA annual convention.



Welcome to Atlanta

THE MEDICAL ASSOCIATION OF GEORGIA will hold its 117th Annual Session in Atlanta, May 13-16, 1971. The members of the Fulton, DeKalb and Cobb County Medical Societies extend warmest welcome to the other members of MAG. Anyone of us here will consider it a privilege to answer any call from anyone of you for help. Carter Smith, Jr., is the Chairman of the Local Arrangements Committee and has arranged an excellent program of entertainment. We look forward particularly to seeing you and your ladies at the Fulton County Medical Society Social Hour which will be co-sponsored by the Fulton National Bank on Saturday evening, May 15 at 6:30.

The Braves will be in town, Underground Atlanta will be swinging, and Stone Mountain and the Cyclorama are as durable and interesting as ever. The Atlanta Symphony will be under the baton of guest conductor James Levine and the High Museum of Art will have a special showing on Nineteenth Century American Landscape paintings—"The Beckoning Land." If you've never visited Atlanta's beautiful Memorial Arts Center, you have a real treat in store. As a special feature, attractive to the ladies, one of Atlanta's beautiful mansions will be open to the public as a "Decorators Show House" sponsored by the Women of the Symphony. Warning—tickets to many of these events should be arranged in advance.

When you combine these (and other) attractions with the excellent program that has been arranged by Preston Ellington, the 117th Annual Meeting of the Medical Association of Georgia should be one of the best you've ever attended. We look forward to seeing you.

*Robert E. Wells, M.D., President
Fulton County Medical Society*

Leadership Conference— New Member Indoctrination

THE 13th ANNUAL County Society Officers' Conference was held February 6 and 7, 1971 at the Sheraton-Biltmore Hotel in Atlanta. Sponsored by the MAG Public Relations Committee under the direction of J. Watts Lipscomb, M.D., Chairman, the Conference was designed as an indoctrination program for new members as well as a training session for new MAG officers.

The Conference was divided into five panels, with the first featuring a slide presentation showing the various activities at MAG Headquarters. This presentation was especially geared to the new members, who might have been unaware of the services of MAG.

Other panels covered the structure of MAG and committee organizations, the function of the *Journal*, activities of the MAG Foundation, involvement with various government programs such as OCHAMPUS, Georgia Regional Medical Program and others, services available through AMA, responsibilities of county

society officers, and the process of claims review in Health Care Programs. Also, the past, present and future of medicine, as well as Computerized Medicine were discussed.

Joseph A. Sabatier, Jr., M.D., member of the AMA Committee on Quackery and Dr. Noah Langdale, Jr., President of Georgia State University, were featured speakers on the program. A tour of the Medical Association of Georgia Headquarters building was conducted February 6, followed by a MAG-sponsored Social Hour and entertainment at the Sheraton-Biltmore Hotel.

Plans are now being developed for the 1972 Conference.

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL FEBRUARY, 7, 1971

Finance: Voted \$300 as a loan to the Georgia Medical Care Foundation, Inc., with \$100 to be used for membership in the American Association of Foundations for Medical Care.

Appointments: Nominated John Kirk Train, Jr., M.D., Carson Bergsteiner, M.D., and Leon Curry, M.D., to the Governor for appointment of one as First District Member of the State Board of Health. Voted Paul Henson, M.D., as alternate from Seventh District and Pano Lamis, M.D., as alternate to the Chairman of the Committee on Medical Education, on the GRMP Regional Advisory Group. Added Harold Harrison, M.D., to the panel of Medicare Consultants, for Vascular Surgery.

Legislation: Voted the following positions:

Oppose HB 84, Metropolitan Atlanta Planning Commission.

Oppose extension of HB 1 (1970) Mental Health Bill of Rights.

Oppose HB 61, Duties of Secretary of Composite Board of Medical Examiners.

Support proposed bill to abolish Commercial Blood Banks.

Oppose HB 207 Comprehensive Prepaid Hospital Care.

Restated previous opposition to Optometry Freedom of Choice (SB 103).

Restated previous opposition to compulsory inclusion of clinical psychology coverage in insurance contracts. (Proposed)

Abortion: Adopted multiple amendments to proposed bill by Representative Townsend liberalizing the restrictions on this procedure. Voted to oppose the Townsend Bill if physicians are not protected by the inclusion of a clause excusing them on religious or moral grounds.

Osteopaths: Voted to accept responsibility for payment of claims received under CHAMPUS from all Osteopathic physicians holding either full or limited license.

County Societies: Voted to authorize the Secretary of State to allow use of the name Medical Association of Metropolitan Atlanta, Inc., by that County Society.

Officers: Voted to instruct the Committee on Constitution and Bylaws to prepare amendment language 1) combining the officers of Secretary and Treasurer, and 2) making the Treasurer an elected officer and Chairman of the Committee on Finance.

Next Meeting: 10:00 a.m., Saturday, March 6, 1971. Macon Hilton Hotel.

AMA RURAL HEALTH CONFERENCE

The American Medical Association's 24th National Conference on Rural Health will be held March 25-26 at Atlanta, Ga. (Atlanta Marriott Motor Hotel).

Theme for the 1971 meeting will be "Community Health Programs for Tomorrow." The conference is sponsored by the AMA's Council on Rural Health. Conference goals are four-fold: To discuss effective ways for delivery of health services to all people in rural areas; To develop planning methods for community organizations for health services; To assess the effect of environmental factors on health, safety and well-being of people living in rural areas; To review methods for efficient utilization of health resources.

Keynote address at the opening session Thursday morning, March 25, will be presented by Vernon E. Wilson, M.D., Rakville, Md., administrator of the Health Services and Mental Health Administration of the Department of Health, Education and Welfare. L. J. Snyder, M.D., of Fresno, Calif., chairman of the AMA Council, will preside. Others on the opening session program are J. J. Lancaster, Ed.D., Athens, Ga., head of the Department of Extension Education, University of Georgia; J. Frank Walker, M.D., Atlanta, vice speaker of the AMA House of Delegates; Craig Bruno, a physician's assistant from Plymouth, N. C.; Mrs. Martha K. Schwebach, R.N., of Estancia, N. M.; Eddie J. Bivens of White Salmon, Wash.



MISCELLANY

WHEN THE IDEA for a President's Page to be printed each month in the Medical Association of Georgia *Journal* was first mentioned, as I recall, the subjects to be discussed included emphasis on items of special interest to physicians, or opinions of the President. Hence, I believe considerable editorial license may well have been intended.

Several years ago, a friend and colleague, Dr. C. F. Holton, Savannah, Georgia, published a poem in *The Bulletin* of the Georgia Medical Society. I need not dwell on its appropriateness at any time, nor on the basic truths contained therein.

AIN'T GOT TIME

Ain't got time to go a-fishing
Ain't got time to relax
Ain't got time to sit a-wishing
Got to pay my income tax.

Ain't got time for my family
Hardly know the children's names,
Ain't got time to sit and listen
To their tales and childish games.

Ain't got time to romp and play
Ain't got time to go to church,
Got to work fourteen hours each day
Can't leave my business in the lurch.

Ain't got time for mirth or laughter
Ain't got time to take a drink.
Ain't got time for the hereafter,
Ain't got time to sit and think.

Ain't got time to hit a golfball
Ain't got time to sink a putt.
Got to give my very all
To keep the wolf from my hut.

Ain't got time for a vacation.
That's all foolishness any way.
I can get my recreation
Doing things that bring in pay.

Ain't no one can take my place,
Ain't got time for story or fable.
Think I'll have to step-up my pace
Got to make it while I'm able.

Ain't got—Good Morning, GABRIEL!!
—C. F. Holton, M.D.

For the past 13 years, the Medical Association of Georgia has sponsored a program for edification and training of County Medical Society Officers, and has recently added "indoctrination of new members." The subjects were discussed expertly and adequately by members of MAG and the Staff of the Medical Associa-

PRESIDENT'S LETTER / Continued

tion of Georgia during the weekend of February 6 and 7. To those of you who should have attended, you certainly missed a wonderful meeting. The keynote address was given by Dr. Noah Langdale, Jr., President of Georgia State University. The address, needless to say, was a classic—and no attempt to summarize it will be made; however, he made a statement that is quoted herewith:

"At age five, you worship your son and you are his slave.

At age 10, he worships you and he is your slave.

At age 15, he is your imitator.

At age 20, he is either your friend or your foe, depending on the job you have done."

Think that over!

The May issue of the *Journal of the Medical Association of Georgia* will contain information in detail regarding the Georgia Medical Foundation, Inc. It will pay dividends to you to acquaint yourself with this program, and I urge you to read carefully all information emanating from the Headquarters of MAG regarding this program.

Sincerely yours,



F. G. Eldridge, M.D.

President, Medical Association of Georgia

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

FOUNDED 1904

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Accredited by the Joint Commission on Accreditation and Certified for Medicare

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Contact: (1) Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

(2) Samuel N. Workman, M.D.
Chief of Clinical Services

(3) Charles W. Neville, Jr., M.D.
Associate Professor of Psychiatry
and Medical Director

Area Code 704-254-3201



NONPENETRATING WOUNDS OF THE HEART AND GREAT VESSELS

PANAGIOTIS N. SYMBAS, M.D., *Atlanta*

THE INCREASING NUMBER of automobile accidents in recent years has produced a corresponding rise in blunt injuries to the heart and great vessels. The shearing, torsion, and compressive forces associated with blunt chest trauma may result in contusion or even rupture of the heart, rupture of the interventricular septum, injury of the aortic, mitral, or tricuspid valve apparatus, rupture of the aorta or avulsion of one or more great vessels.

Contusion of the heart is the most common nonpenetrating cardiac lesion and varies from subepicardial or subendocardial petechiae to transmural necrosis. The electrocardiographic manifestations range from transient dysrhythmias or conduction defects to ST-T wave abnormalities or the full picture of myocardial infarction. These findings, particularly the dysrhythmias, may be present only for a short time after the injury; or in the case of findings indicative of muscle injury may not appear until hours or days after the event. Myocardial contusion may present the full clinical picture of myocardial infarction or may present as heart failure. Rupture of the interventricular septum and injury of the cardiac valves may also present with cardiac failure or may demonstrate a typical murmur of ventricular septal defect or aortic, mitral, or tricuspid regurgitation. These murmurs may appear immediately, several hours, or even days after the injury. The careful physical examination of patients with blunt chest trauma over the days and weeks following the event is necessary to permit detection of many valvular or shunt lesions as well as post traumatic pericarditis.

The management of myocardial contusion is that of myocardial infarction except that anticoagulation is contraindicated. Rupture of the septum or injury of a valve apparatus is managed similarly for the first two or three months if heart failure can be medically controlled. The lesion should then be electively repaired if cardiac catheterization and angiography indicate the presence of a hemodynamically significant defect. Patients with uncontrollable congestive heart failure should have immediate diagnostic studies and surgical repair of significant lesions.

The common manifestations of traumatic rupture of the aorta are severe chest and midscapular pain, dyspnea, increased pulse amplitude, and hypertension of the upper extremities. Hoarseness, evidence of a superior vena caval syndrome, paraplegia and anuria are less frequent manifestations. Patients with rupture of the aorta, although occasionally without obvious signs of external injury, usually have evident associated injuries of the skeleton, abdominal viscera, or central nervous system. These coexisting injuries may mask the signs of aortic rupture. The signs of paraplegia, commonly due to spinal cord injury; low urine output or anuria, often due to hypovolemia; and chest pain or hemothorax, often due to rib fractures and other thoracic injuries can also be due to aortic rupture. For

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

this reason, any patient having sustained severe blunt trauma should be suspected of having aortic rupture particularly if increased pulse amplitude and upper extremity hypertension are present. Chest roentgenography is of considerable diagnostic value in patients with aortic rupture. Widening of the superior mediastinal shadow, disappearance of the aortic knob shadow, depression of the left main stem bronchus and the displacement of the trachea to the right are the common x-ray abnormalities. However, other factors including pre-existing mediastinal lesions, mediastinal hematoma from rupture of the small mediastinal vessels, and the inability to obtain chest films of good quality in these severely injured patients may be responsible for the presence of the roentgenographic findings suggesting aortic rupture. The diagnosis of aortic rupture can be definitively established only by aortography and this should be done before surgical treatment is instituted. Surgical repair of this lesion should be performed as soon as the diagnosis is established and requires particular attention to provisions for perfusion of the kidney and spinal cord.

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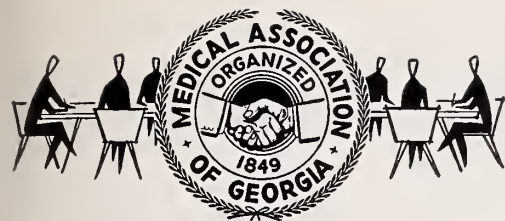
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THE ASSOCIATION

NEW MEMBERS

Barbee, Charles W. DE-4—Wayne—Su	USA Hospital Fort Stewart, Georgia 31313
Boone, Paul D. Active—S. Ga.—Path	Pineview General Hospital Valdosta, Georgia 31601
Butler, Richard H. Service—Fulton	P. O. Box 20636 Atlanta, Georgia 30320
Collins, Mr. Cleve B. Student—Richmond	Medical College of Georgia Augusta, Georgia 30902
Dyckman, Edward DE-2—Fulton—I	1365 Clifton Road, N. E. Atlanta, Georgia 30322
Fernandez, Manuel A. Active—Thomas-Brooks- Grady—P	Southwestern State Hospital Thomasville, Georgia 31792
Hansen, Robert F. Service—Fulton—PH	50 Seventh Street, N. E. Atlanta, Georgia 30309
Hudson, Carlton B. Active—Bartow—R	113 Allison Circle Cartersville, Georgia 30120
Meyer, Mr. Barnard C. Student—Richmond	1309 15th Street Augusta, Georgia 30901
Moye, Mr. Robert J., Jr. Student—Richmond	Aumond Villa Apts. Augusta, Georgia 30904
Muller, Gerald B. Active—Thomas-Brooks- Grady—OBG	918 S. Broad Street Thomasville, Georgia 31792
Oteiza, Jorge A. Active—S. Georgia—GP	Pineview General Hospital Valdosta, Georgia 31601
Payne, John F. Active—Thomas-Brooks- Grady—OR	918 S. Broad Street Thomasville, Georgia 31792
Shields, Joseph D., III Active—Bibb—I	724 Hemlock Street Macon, Georgia 31201
Simpson, Marshall A. Active—Muscogee—P	The Bradley Center Columbus, Georgia 31901
Reynolds, G. Thomas Active—Thomas-Brooks- Grady	918 S. Broad Street Thomasville, Georgia 31792

PERSONALS

Fifth District

Phinizy Calhoun has been elected to the Executive Committee of the Section of Ophthalmology of the Southern Medical Association.

John Rhodes Haverty has been tapped into membership in Omicron Delta Kappa, national leadership honor fraternity.

J. Willis Hurst has been named recipient of West Georgia College's 1971 Distinguished Alumnus Award.

Bruce Logue recently addressed the 1971 Annual Convention of the Medical Society of the State of New York.

Seventh District

John I. Dickinson was a recipient of the Man and Boy Award for distinguished service, given by the Boy's Club of Rome.

George Mims was guest speaker at Plains Baptist Church in January.

Tenth District

Robert G. Ellison was elected president of the Society of Thoracic Surgeons at its annual meeting in January.

Robert Morris Paty was honored by the Covington Elks Club in January upon his retirement after 48 years of service.

Norman B. Pursley was honored in January upon his 20th anniversary as superintendent of Gracewood State School and Hospital.

DEATHS

Charles G. Boland

Charles G. Boland, Sr., died January 7 in a private hospital at the age of 72.

An Emory graduate, Dr. Boland had practiced medicine in Atlanta since 1923. He was a staff member of Georgia Baptist Hospital and former instructor in the hospital's nursing school.

Dr. Boland was a member of the Fulton County Medical Society, Medical Association of Georgia, and the Peachtree Road Methodist Church.

He is survived by a son, a daughter and two brothers.

Howard L. Cheshire

Howard L. Cheshire died of a heart attack January 7 in Thomasville. He was 54 years old.

He attended Emory University and was graduated from the University of Georgia, where he also received his medical degree. He served briefly in the armed forces and began practice in Thomasville in 1947.

A member of the staff of Archbold Memorial Hospital, Dr. Cheshire also belonged to the Medical Association of Georgia and the Georgia Obstetrical Society.

Leo P. Daly

Leo P. Daly, past president of the staff of St. Joseph's Infirmary and one of the organizers and first presidents of Standard Federal Building and Loan Association, died February 6 in an Atlanta hospital.

ASSOCIATION / Continued

He was graduated from Emory University Medical School in 1911, interning at Grady Hospital and New York City Hospital.

Dr. Daly was on the staff of St. Joseph's, Georgia Baptist Hospital, Emory University Hospital, Crawford W. Long Hospital and Piedmont Hospital. He was also chief of staff of the Free Cancer Home for many years.

Dr. Daly was a veteran of World War I and a charter member of American Legion Post 134. He was a member of the Medical Association of Georgia, Fulton County Medical Association, Phi Rho Sigma Medical Fraternity, the Cathedral of Christ the King and the Knights of Columbus Holy Name Society.

He was a former member of the Capital City Club, Atlanta Athletic Club and the Ansley Park Golf Club.

Dr. Daly is survived by his widow and a sister.

Hiram J. Williams

Hiram Joseph Williams, 74, died January 28 at his home in Cordele.

Dr. Williams was a member of the First Presbyterian Church of Cordele, a charter member and past president of the Cordele Lions Club and was an aviation medical examiner for the FAA.

He was also a member of Cordelia Masonic Lodge, Al Sinah Shrine Temple in Macon, Pine Hill Country Club, the Aero-Space Medical Association, Medical Association of Georgia, and the American and Southern Medical Associations.

Dr. Williams is survived by his widow, Mrs. Julia M. Seaman Williams; a son, Richard M. Williams of Cordele and three grandchildren.

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dextromethorphan HBr	30	15
alcohol	10%	

The scored, elliptical tablet is light violet. The elixir is deep violet in color and grape-flavored.

ACTIONS Each component of Nilcol has been selected to provide symptomatic relief of congestion and cough in upper respiratory disorders.

Phenylpropanolamine hydrochloride is a vasoconstrictor which reduces congestion of the nasopharyngeal mucosa. Chlorpheniramine maleate, a widely used antihistamine, helps to control allergic symptoms. The expectorant is glyceryl guaiacolate which helps to increase the secretion and decrease the viscosity of fluids of the respiratory tract. Dextromethorphan is a well-known, centrally acting antitussive. Nilcol may minimize the need for topical decongestants.

INDICATIONS Nilcol is indicated for nasal and bronchial congestion; coughs and other symptoms of respiratory infections including influenza and the common cold; other respiratory conditions such as sinusitis, allergic rhinitis or hay fever.

CONTRAINDICATION Hypersensitivity to any ingredient.

PRECAUTIONS Because of the possibility of drowsiness, patients should be cautioned against driving and operating machinery. Administer with caution to patients with hyperthyroidism, hypertensive cardiovascular disease, diabetes mellitus and liver disease. Use in pregnancy is not recommended.

ADVERSE REACTIONS Anxiety, restlessness, tension, insomnia, tremor, weakness, headache, vertigo, sweating, nausea, and vomiting may possibly occur.

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MAG MEDICAL EDUCATION CONFERENCE

Report of Group A—Topic: Allied Health Personnel —The need for inclusion of the Team Concept in Medical Education

The consultant to the groups on the topic of Allied Health Personnel presented to each group the mechanism established by AMA to deal with the proliferation of allied health professions. Doctor Lehmkuhl set the stage for the discussions with the current status of the mechanism.

Training and educational programs for established allied health occupations are evaluated by appropriate review bodies containing representatives of the particular allied health occupation and representatives of particular medical specialties. Recommendations are acted upon by the Council on Medical Education via the Advisory Committee on Allied Health Professions and Services, which has established a Panel of Consultants consisting of a representative from each of the 14 national professional associations and societies which collaborate with the AMA in accrediting allied health educational programs in 15 occupations.

Another Council of the AMA, one on Health Manpower, concerns itself with the development of criteria and guidelines for new and emerging allied health occupations. The Committee on Emerging Health Manpower reviews proposals for new occupations and decides if they should be recognized. Programs of education and training can then be reviewed for approval.

Three groups, the AMA, the Association of Schools for Allied Health Professions and the National Commission on Accreditation, have authorized a study to examine the current status of approval mechanisms for education and training programs. A second goal of the study group is to develop models for the review, approval and accrediting of health occupations programs. The group will also make recommendations for licensure, certification and capabilities for the separate occupations.

Group discussions centered about the education and training, utilization, acceptability, and legal responsibility of allied health personnel. There was consensus on a number of points.

EDUCATION AND TRAINING

The shift of training programs from hospitals to educational institutions has several advantages. Academic credit allows opportunity for career mobility, both vertical and horizontal. There is some degree of standardization for the employer to understand what the employee is able to do. Clinical experience is still an important necessity of academic programs. There is no objection to physicians who "train their own" but the employees are often locked into their employer's world.

UTILIZATION

The use of allied health personnel implies a team approach to medical practice. Educational programs should include opportunities for teams to learn together if they are going to work together. Physicians must learn how to best utilize the allied health occupations to increase their efficiency.

ACCEPTABILITY

The public must be educated about the place of allied health personnel in medical care practices. In gen-

eral, the public accepts these occupations to a greater extent than the physician is able to utilize them.

LEGAL RESPONSIBILITY

There is general agreement that legal responsibility should rest with the physician who employs assistants. They should work under his supervision. This should minimize the need for licensing allied health professionals.

Report of Group B—Topic: Community Health Centers—Opportunity for Cooperation and Interaction by the Medical Schools

The Topic B Workshops on medical education in the Community Health Centers used the Southside Community Health Center in Atlanta as the model for their discussions. The day to day functioning of the Center and its methods of operation were reviewed by the Center's former administrator. The experimental nature of the Center as a means of health care delivery was emphasized by the panel members.

OPPORTUNITY FOR UNDERGRADUATE MEDICAL EDUCATION

The participants agreed that the Community Health Centers offered an excellent opportunity to medical students for the gaining of clinical experience. However, in the case of the Southside Center, there were no students participating on a regular basis, due to the decision made by the area residents. The population served by the Center identified medical care provided by medical students, interns and residents with the type of "impersonal" medical services provided by the staff of Grady Hospital. The Community, therefore, decided against the use of anyone but a fully qualified, experienced physician. Fortunately, the residents have become more acceptable of the idea of medical care being provided by supervised medical students. Plans are being made by Emory to initiate a program at the Center for its medical students. Emory's medical students have been very interested in working at the Center and some of those who volunteered have worked at the Center without being identified as medical students. The topic consultant advised the participants that Community Health Centers in other parts of the country did provide clinical training programs for medical students.

INTERACTION WITH PHYSICIANS IN PRIVATE PRACTICE

Although no formal methods for participation by private physicians have been developed, there is great potential in the Southside Community Health Center for their continuing education working with the medical school staff. The Fulton County Medical Society members who have been involved in the development and operation of the Center have benefited from the experience and have gained knowledge of the problems of practicing medicine in such an environment. Some of the workshop participants envisioned the possibility of developing cooperative centers around the state with medical school staff, including students, and private physicians acting together to provide services within the framework of a learning situation.

EDUCATION / Continued

EDUCATION PROGRAMS AT THE COMMUNITY HEALTH CENTER

The Community Health Center can be the site of training programs for allied health personnel. However, a frequent problem encountered is the poor educational background and almost total lack of preparation of area residents to participate in such training. The experience of the Atlanta Center reflected this in that basic reading and writing skills had to be taught, first, to most of the trainees. Also, once these people complete their training, they are unable to get a job elsewhere because of their limited skills. As better educated individuals are identified, however, they are funneled into vocational or technical schools to acquire skills which cannot be learned at the Center.

CONCLUSIONS OF WORKSHOP DISCUSSIONS

1. The Community Health Center should be tested in a variety of locales to assure its viability in different population areas. The Centers, or the HMO's, should be viewed as just one of the methods of health care delivery.

2. More models of medical education should be developed and experimented with—one possibility being clinical training for medical students on a regional basis at community hospitals, medical centers or community health centers.

3. Greater opportunity should be afforded the private physician to function within community health centers, not only to provide him with information on the activities of the centers but also to allow him a chance to continue his medical education by functioning in the Community Health Center setting.

Report of Group C—Topic: Rural Medicine—Medical Education's Contribution to the Vanishing Practitioner

Dr. Robert E. Reynolds, Medical College of Georgia, distributed a report showing, through charts, graphs and tables, the status of health care in Georgia. The State's population per physician ratio is higher than the national average, with 26 counties having zero or only one physician.

CAUSES OF LOSS OF RURAL PHYSICIANS

The discussion groups felt that the movement of physicians away from rural areas is due in part to the "rat race," whereby the rural physician is, in effect, on call 24 hours a day, seven days a week, with very little time to spend on leisure, continuing education, or family matters. The groups felt that medical schools are also partly responsible because of their emphasis on specialization and de-emphasis of family practice. The economics of treating patients in poor rural areas also tends to make an urban practice more attractive.

EMERGENCY MEDICAL CLINIC IN RURAL AREAS

One of the issues discussed centered on the concept of an emergency medical clinic, designed to draw cases of a non-emergency nature away from hospital emergency rooms. This clinic would be open evenings, weekends and holidays, and would be staffed by whichever physician was on call at the hospital. Trained office personnel would also be hired on a part-time basis. Such a clinic, separate from both the physician's office and the emergency room of a hospital, would help avoid confusion on the patient's part—in other words, the patient would know to go to the clinic, which would hopefully be located adjacent to a hospital, when health services were needed outside of standard office hours.

The project would involve five physicians, would be set up in a mobile trailer (it could also be used as an emergency medical care unit) and could be an accredited facility of a medical school. In this respect, it would serve as an educational situation, whereby medical students could staff the clinic with their preceptor. Such an experience could accustom a student to the demands of family practice, remove much of his wariness at attempting such a practice, and make rural medicine more appealing.

Several doctors spoke against this proposal, feeling that it would reinforce patient feeling that physicians should be at anyone's disposal at all times. Another view was that people will continue to utilize hospital emergency rooms as treatment centers outside of regular office hours, and that this would remain true even if physicians kept their offices open on the nights they were on call. All of the groups were in agreement, however, that a preceptorship is an excellent teaching situation.

ENCOURAGEMENT OF RURAL PRACTICE

Dean Fordham of the Medical College of Georgia reported that his institution is encouraging rural practice through its preceptorship program, proposed training and utilization of physicians' assistants and continuing education courses.

CONCLUSIONS

The discussion groups felt that the greatest deterrents to establishing effective rural health care is lack of transportation to health facilities and lack of financial backing. They also concurred that the burden of encouraging students to practice in Georgia will fall chiefly on the Medical College of Georgia, as Emory is oriented towards graduating students in the field of medical education and research.

*Medical Education Conference,
February 26-28, Callaway Gardens,
Pine Mountain, Georgia.*

THE MONTH IN WASHINGTON

President Nixon promised that every effort will be made to keep bureaucracy at a minimum in connection with his new overall national health program even before he disclosed its details.

"... We do not want the doctors and those in the medical profession to be smothered under a whole, huge bureaucracy and under a great pile of government forms," he said in a speech at the 20th annual meeting of the American College of Cardiology prior to his acceptance of the college's 1971 Humanitarian Award.

Needs Support

Nixon said he recognized that there is no program for medical care that would be good for the patient unless it is supported by physicians and has the co-operation of the medical profession.

"So we want your advice, we want your cooperation, we want to work together with you in developing a program that will do what is needed to be done and do the best for our patients, your patients, but also that will enable you to meet your responsibilities as unhampered as is possible by federal bureaucracy, red tape and the like," he said.

"That is our objective and I will simply say . . . that as this debate goes on through the year that I know that we will have your cooperation.

"I know the dedicated men and women that are in this profession. And I can assure you that we will listen. We want your advice because, as I said in the state of the union message, we have one great goal."

Improving Care

In the state of the union message, the President said:

"As a fourth great goal, I will offer a far-reaching set of proposals for improving America's health care and making it available more fairly to more people.

"I will propose:

"A program to insure that no American family will be prevented from obtaining basic medical care by inability to pay.

"I will propose a major increase in and redirection of aid to medical schools, to greatly increase the number of doctors and other health personnel.

"Incentives to improve the delivery of health services, to get more medical care resources into those areas that have not been adequately served, to make greater use of medical assistants and to slow the alarming rise in the costs of medical care.

"New programs to encourage better preventive medicine, by attacking the causes of disease and injury, and by providing incentives to doctors to keep people well rather than just to treat them when they are sick.

Ask Fund Increase

"I will also ask for an appropriation of an extra \$100 million to launch an intensive campaign to find a cure for cancer, and I will ask later for whatever additional funds can effectively be used. The time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dread disease. Let us make a total national commitment to achieve this goal.

"America has long been the wealthiest nation in the world. Now it is time we became the healthiest nation in the world."

In his budget message, Nixon said he later would send to Congress a message "that will set out a nation-

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WASHINGTON / Continued

al health strategy for the 70's and propose significant changes in the federal role in the nation's system of health care."

"This strategy will seek to expand preventive care, to train more doctors and other health personnel, to achieve greater equity and efficiency in the delivery of health services," he said. "It will include a new health insurance program for all low-income families with children."

Tight Control

The Nixon Administration asked Congress for tighter government control over any peer review setup for medicare and medicaid than would be provided by the so-called Bennett amendment approved by the senate last year.

Elliot L. Richardson, secretary of Health, Education and Welfare, told the House Ways and Means Committee:

"We agree with the objective of assuring an expanded role for the medical profession in peer review activities and recognize the need for improvement of utilization review procedures. However, certain modifications in the senate provisions would be desirable. For example, we do not think that the secretary of HEW should be required to use medical-society sponsored groups in situations where there may be a highly qualified review organization in the area that has already demonstrated its ability to perform well. We also favor giving the secretary some greater flexibility to permit, through regulations, variations in the structure and patterns of operation of peer review groups."

Richardson was testifying on H.R. 1 of the 92nd Congress. The social security measure includes provisions for peer review and other changes in medicare and medicaid. Both chambers of Congress passed such legislation last year but the senate added so many amendments to the house-passed bill that congressional leaders decided it would be futile for a house-senate conference committee to try to reconcile the differences. The house committee made the legislation the first order of business this year and the legislation was expected to get through Congress within a few months.

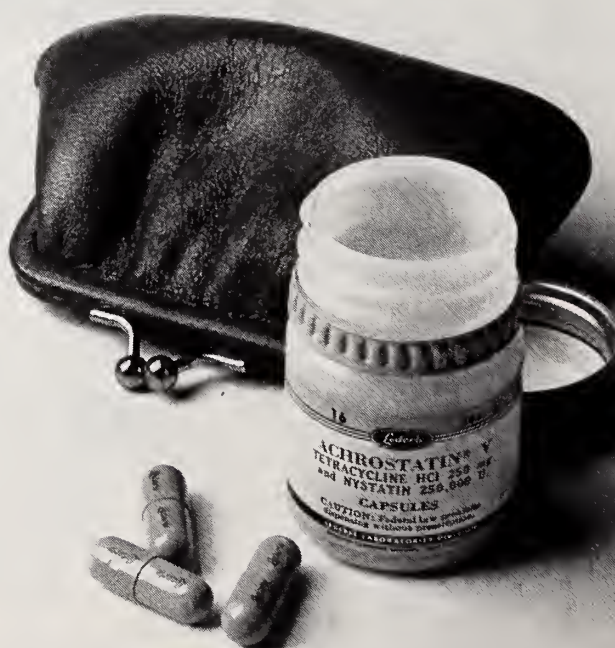
Richardson Request

Richardson again asked for authority to use health maintenance organizations (HMO's), or prepaid group practice, for the government programs. He also renewed a request for authority to limit physicians' fees and other provided costs under medicare. Both provisions were approved in varying forms by the house and senate last year, and consequently it appeared likely that some versions of them, along with peer review, would become law in the first half of this year.

Richardson said HMO's would mean progress toward "our goal of emphasizing preventive medical care." He added:

"We believe that HMO's can help solve many of the problems facing the health care system today—the uncontrolled rise in health care costs, over-utilization, particularly of high cost services, disorganization, improper allocation of resources, inadequate emphasis on preventive care and inefficient use of available health manpower. In the long run, the encouragement of HMO's may be the most important step we

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can take to stimulate the restructuring of the health delivery system. We hope that health maintenance organizations, and their use by beneficiaries, will expand greatly in the future, and we believe that there can be significant long-run savings in program costs due to the HMO option."

Increase Limitation

Concerning the proposed limitation on increases in physicians' fees, Richardson said:

"Another major change relating to medicare reimbursement that is recommended by the Administration is one which would limit medicare's recognition of prevailing charge increases to rates that economic data indicate would be fair to all concerned. We believe that if recognition of fee increases is tied to appropriate economic indexes, this will help to assure that the recognition of such increases is appropriately related to developments in other pertinent sectors of the economy."

Economy Measures

Administration sources said HEW later would seek authority for other economy measures to cut medicare costs. These included:

- Reduction of the 60-day period of hospitalization during which beneficiaries pay relatively little.
- Increase the annual \$50 deductible a beneficiary must pay toward his physician's fees under Part B.
- Tighten up on payments to nursing homes for custodial care.

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LETTER TO THE EDITOR

Dear Dr. Woody:

I thought you might be interested in seeing the Physicians' Professional Liability Insurance rates to be charged by the Aetna in Alabama. Aetna filed for the higher rates, and the State Medical Association was able to have Governor Brewer issue an Executive Order preventing the rates from becoming applicable. However, the Association was unable to find a carrier who would write business in the state for the Bureau rates, and they therefore were forced to ask the Governor to rescind his order so that the physicians could obtain coverage even though the premium will be 50 per cent above Bureau rate.

The Aetna policies in force in Alabama were to expire September 15, but Aetna agreed to grant a 90-day extension, pending settlement of the premium negotiations. The new rates will go into effect December 15. All of this reconfirms the fine program we have in Georgia through the St. Paul Insurance Company.

**PREMIUMS PAID BY ALABAMA PHYSICIANS
FOR \$100/300,000 POLICY**

	Bureau Manual Rates	Aetna Rates	Ga. Group
Class I			
Internists, GP's and other non-surgical	147	221	
Class II			
Minor surgery	257	389	
Class III			
GP's (major surgery), oph- thalmologists, proctol- ogists	556	839	
Class IV			
Cardiac surgeons, oto- laryngologists, general sur- geons, thoracic surgeons, urologists, vascular surgeons	741	1,119	
Class V			
Anesthesiologists, neurosur- geons, ob-gyn, orthopedists, otolaryngologists, plastic surgeons	926	1,399	571

Cordially,
William W. Moore, M.D., Chairman
Committee on Insurance and Economics

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MEMBER



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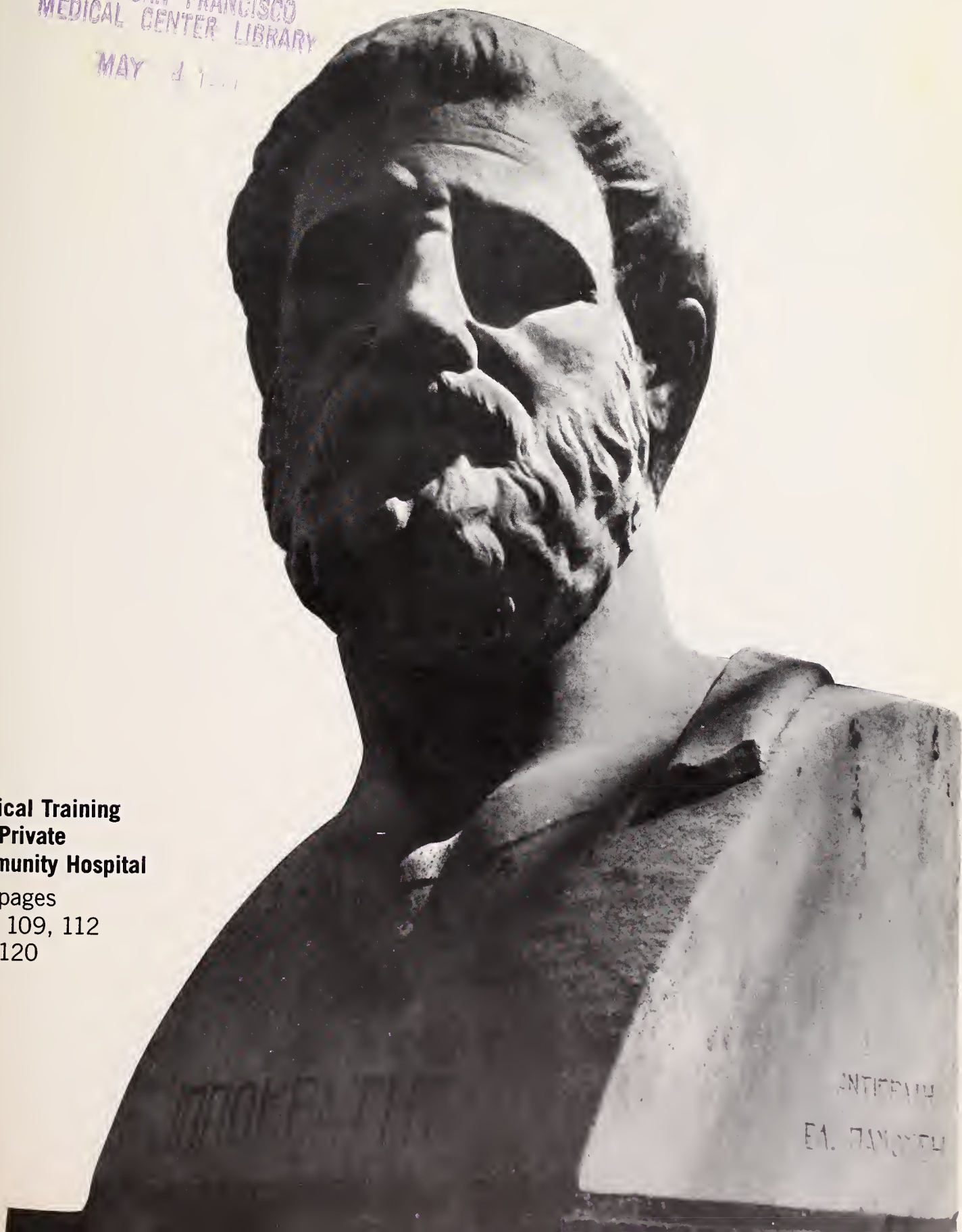
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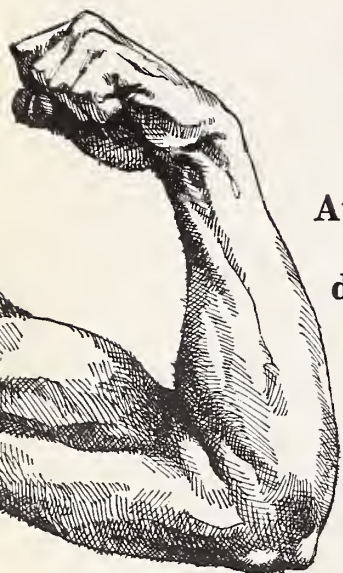
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**Surgical Training
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IF MORE MEN CRIED

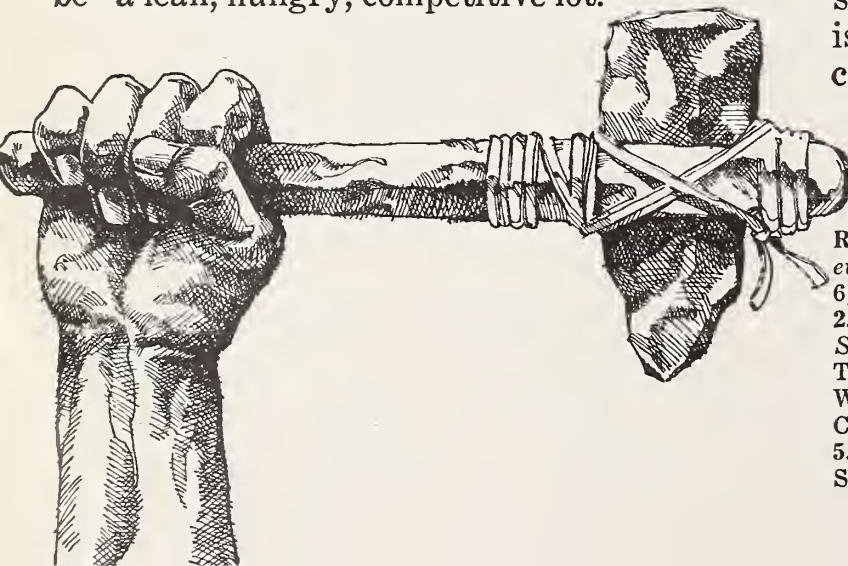


At least seventy-five out of one hundred adults with duodenal ulcers are men.¹

Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."²

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."²

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."³



Big boys don't cry. If more men cried maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total



their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.⁴ Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.

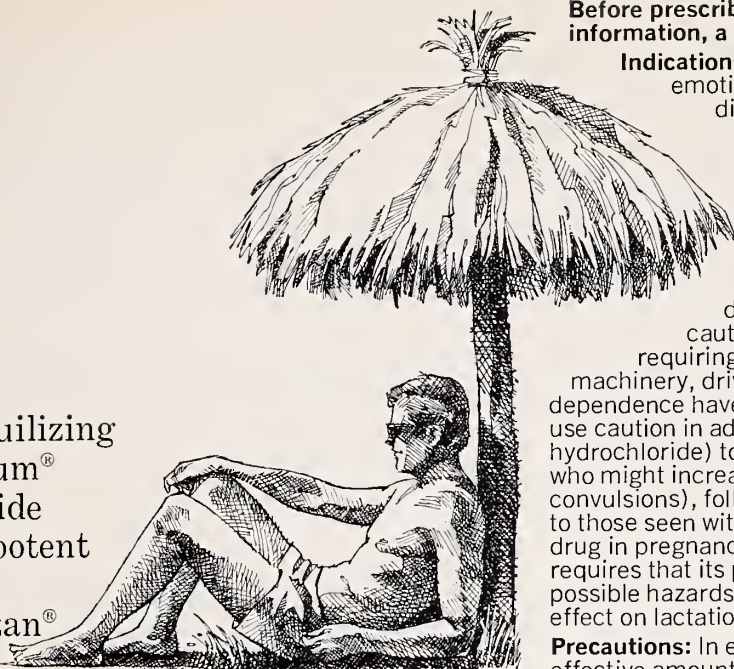
Take away stress, you can take away symptoms.

There is no question that stress plays a role in the etiology of duodenal ulcers. Alvarez⁵ observes that many a man with an ulcer loses his symptoms the day he shuts out the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax.[®] For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that com-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M., et al. (eds.): *Harrison's Principles of Internal Medicine*, 6, New York, McGraw-Hill Book Company, 1970, p. 14. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff: Stress and Disease*, ed. 2, Springfield, Ill., Charles C. Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 1. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.

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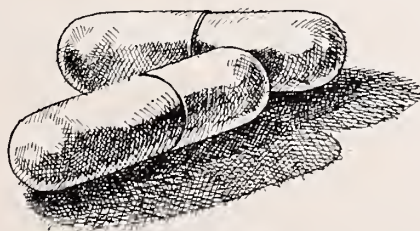


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Bust of Hippocrates at entrance to Piedmont Hospital. Cover design by Bob Hamill.
Atlanta. Photograph by Pat Thigpen.

Right Paraduodenal Hernia Into the Fossa of Waldeyer

WILLIAM GRAHAM SIMS, M.D., JOHN E. SKANDALAKIS, M.D., Ph.D., F.A.C.S., and
STEPHEN W. GRAY, Ph.D., *Atlanta*

THE WORD "HERNIA," meaning the bulging of a viscus or other structure through an aperture in the wall of the cavity which contains it, brings to mind a visible protuberance, a lump where no lump should be, often as evident to the patient as to the physician. The internal abdominal hernias do not fit this picture. Uncommon, difficult to detect, frequently asymptomatic, with confusing anatomy and obscure etiology, they nevertheless account for about one per cent of intestinal obstructions usually with strangulation (Mitchell 1953, Jones 1964).

Zimmerman and Laufman (1953) defined a true internal hernia as a defect in the peritoneal development within the normal confines of an intact endo-abdominal fascia. Such hernias may be large or small, congenital or acquired. They may occur in a wide variety of locations (Table I). By Zimmerman's definitions, hernias in obturator, sciatic or diaphragmatic locations are excluded.

1939). Only rarely has cecum, ascending colon (Jones 1964) or sigmoid colon (Bottoms 1965) been reported. The surgical significance of these rare hernias has not been stressed in the literature.

The paraduodenal hernias occur in peritoneal pockets or fossae. They were first mentioned in 1742 by Hensing. Treitz in 1857 gave us the first concept of the anatomy of the paraduodenal fossae and hernias. Moynihan in 1899 summarized earlier work and described nine paraduodenal fossae into which herniation could occur. Both Treitz and Moynihan believed in the acquired origin of hernias by gradual enlargement of the existing fossa. The congenital nature of the hernias was advanced later by Hertzler (1919) and Andrews (1923). In 1932 Papez suggested that the sac is derived from the embryonic umbilical coelomic lining which remained around the intestinal loops when they returned to the abdomen in the third month of fetal life. This view has been supported by Batson (1955) and by Laslie, Durden and Allen (1966).

The following case is an example of a subtotal strangulated hernia in the mesenterico-parietal fossa of Waldeyer (Figure 1). Moynihan (1906) described the fossa of Waldeyer as being in the first part of the mesojejunum, below the duodenum, and behind the superior mesenteric vessels (Figure 2). The fossa will lie on the right of the abdomen with its orifice directed towards the left. The peritoneum of the left leaf of the midgut mesentery lines the fossa; that of the right leaf covers the blind end and then continues directly into the posterior parietal peritoneum. Since this fossa is usually large, small bowel may enter or leave without causing symptoms or obstruction, and can usually be reduced by gentle traction (Thorek 1954).

TABLE I A CLASSIFICATION OF INTRAPERITONEAL FOSSAE AND APERTURES	
I. Retroperitoneal 1. Paraduodenal 2. Paracecal 3. Intersigmoid	III. Endoperitoneal 1. Mesenteric 2. Omental 3. Broad ligament
II. Properitoneal 1. Interparietal 2. Supravesical	IV. Foraminal 1. Epiploic 2. Sciatic 3. Obturator
V. Perineal	

Of these internal hernias about one half are "paraduodenal." They usually contain small bowel, over half of its length (Hansmann and Martin

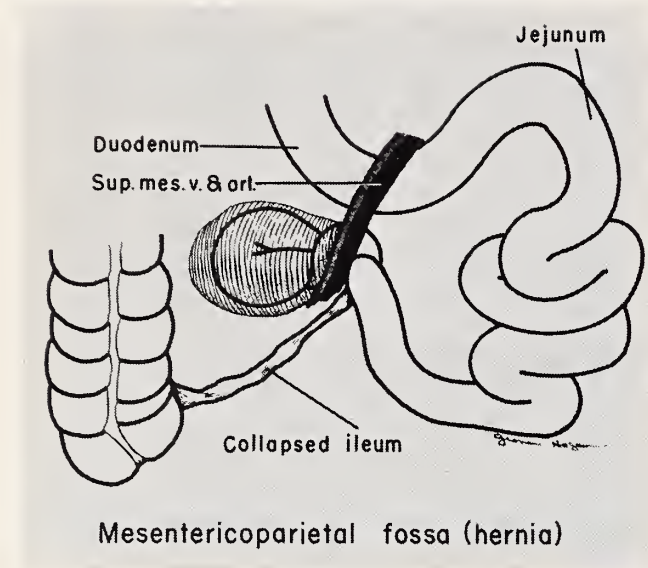


FIGURE 1

Strangulated herniation of the ileum into the mesentericoparietal fossa of Waldeyer.

Case Report

This 35-year-old Negro male sustained multiple contusions and abrasions of the right hip, thigh and knee when he fell from a truck 10 days prior to admission. He soon afterwards developed a symptomatic left inguinal hernia. In addition to the above findings physical examination revealed a small asymptomatic right inguinal hernia. Except for this injury the patient had always been in good health. An appendectomy had been performed 10 years ago.

Bilateral inguinal herniorrhaphies were performed. On the fourth postoperative day he had nausea and abdominal distention which gradually increased. Physical examination on the seventh postoperative day revealed marked distention associated with nausea, lower abdominal tenderness and hyperactive peristalsis. X-ray revealed multiple loops of dilated small bowel suggestive of mechanical bowel obstruction.

At exploratory laparotomy the findings were: a few adhesions of the small bowel, dilated small bowel down to a peritoneal defect in the base of the mesentery with early strangulated obstruction of a partially twisted ileum within the peritoneal defect, and collapsed ileum leaving the hernia sac. This mesenterico-parietal defect extended to the right side of the abdomen, measured 15 cm. in length and was beneath the duodenum. This defect was the fossa of Waldeyer. The superior mesenteric vessels were palpated in its anterior wall. Following upper jejunostomy for decompression, the strangulated portion of the ileum was reduced, 45 cm. resected, and an end-to-end anastomosis performed. The

orifice of the peritoneal defect was closed with interrupted 5-0 suture. Postoperative course was uneventful except for a wound infection that required secondary closure several days later.

Discussion

Approximately 10 theories have been put forward to explain the paraduodenal fossae and the etiology of their hernias (Parsons 1953, Jones 1964). The main emphasis has been on the entrapment of the small intestine behind the ascending or descending mesocolon during the last stage of intestinal rotation and fixation, and on the failure of the primitive mesentery to fuse with the posterior parietal peritoneum around the duodenum and the superior mesenteric vessels.

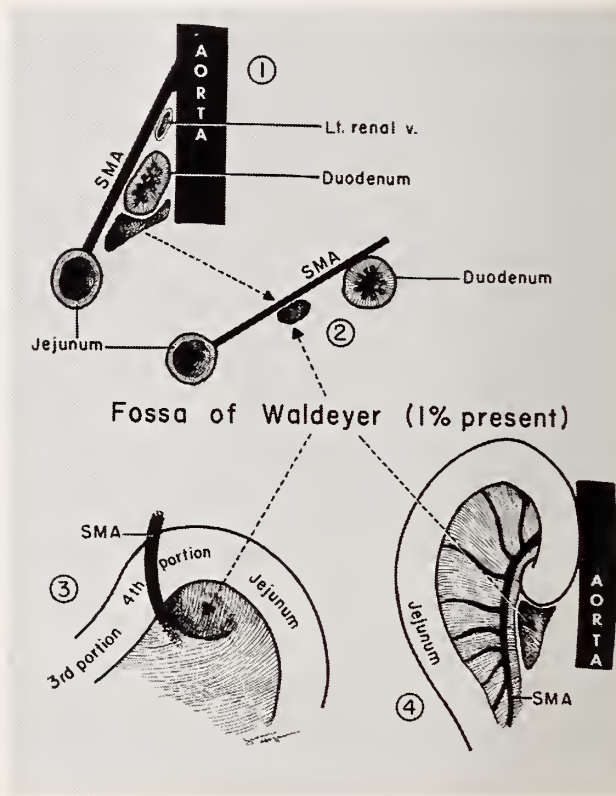


FIGURE 2

Relations of the mesenterico-parietal fossa of Waldeyer to other abdominal structures.

Whether these small paraduodenal fossae or hernias, as in the present case, will enlarge is not known. Andrews (1923) states that enlargement is impossible due to lack of intra-abdominal differential pressure. However, it seems reasonable that progressive enlargement of small paraduodenal hernias may occur with repeated bouts of obstruction (Berens 1963).

The nine paraduodenal fossae described by Moynihan (1899) probably all exist, but only five are found with enough consistency to be of clinical importance (Jones 1964) (Figure 3). Due to dis-

TABLE II
INCIDENCE OF PARADUODENAL FOSSAE

Duodenal Fossa	Eponym	Incidence	Hernia Direction
Inferior Duodenal	Fossa of Treitz	75%-50%	Right
Superior Duodenal	Fossa of Treitz	50%-30%	Right
Mesenterico-parietal	Fossa of Waldeyer	1%	Right
Intermesocolic	Fossa of Brösike	Rare	Right
Paraduodenal	Fossa of Landzert	2%	Left

(Jones, 1964)

tortion at the hernial orifice, a more precise classification of these fossae is often impossible (Parsons 1953).

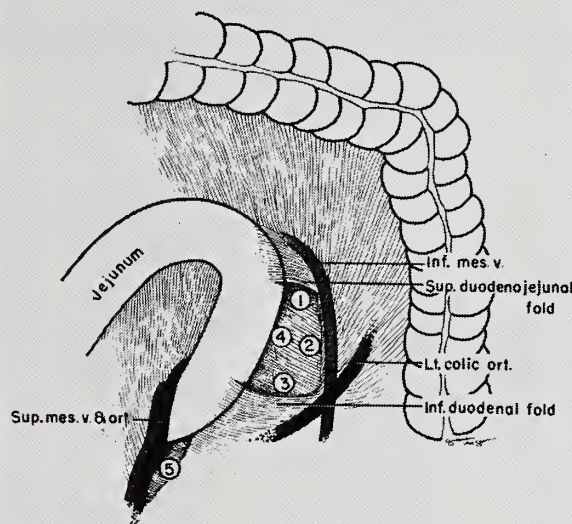
The five significant fossae and their boundaries are listed in Table II.

An important anatomical consideration in any paraduodenal hernia is the vascular pattern in the anterior wall of the hernia sac. The superior mesenteric artery and vein course in the anterior hernia sac wall in paraduodenal hernias directed toward the right side of the midline. The inferior mesenteric vein and ascending branch of left colic artery course in the anterior hernia sac wall in hernias directed toward the left side of the midline (Tanny 1961).

Paraduodenal hernias are usually asymptomatic, though some will present as obstruction, acute or chronic, partial or complete (Kriss 1965). Gallbladder or peptic ulcer disease may be suspected when the symptoms are vague (Lamphies and Cevino 1961). Manfredi (1952) described post-prandial distress following large meals, but not with small meals. Mechanical pressure in the retroperitoneal space may stimulate somatic pain and may be relieved by a change in position (Tanny 1961). Vascular obstruction to the bowel below the site of obstruction will sometimes cause lower G.I. bleeding or infarction (Jones 1964).

Physical findings will depend mainly on the degree, site and duration of obstruction. The diagnosis is mainly by exclusion.

Large paraduodenal hernias can be recognized on x-ray, but small ones are not easily found. There is usually a normal distribution of intestinal loops and no displacement of the stomach. Afferent and efferent loops are occasionally demonstrated. The encapsulated loops of small bowel may show some coarsening of the mucosa, dilatation and stasis. Retroperitoneal displacement may be demonstrated by a lateral film. Positive roentgen findings may be present only when the patient is symptomatic, so that a high index of suspicion is necessary. In four of 12 cases of small encapsulated paraduodenal hernias diagnosed by x-rays, spontaneous reduction had occurred before surgical intervention (Parsons 1953).



The usual anatomy text book nomenclature of paraduodenal fossae

- ① Superior duodenal fossa
- ② Paraduodenal fossa
- ③ Inferior duodenal fossa
- ④ Retroduodenal fossa
- ⑤ Mesentericoparietal fossa

FIGURE 3

The five most frequently encountered paraduodenal fossae.

The surgical treatment of small paraduodenal hernias consists of reduction of the hernia and eradication of the defect, either by closure or by enlargement of the hernia sac orifice. Injury to any major vessel must be avoided. Enterostomy for decompression may be necessary when traction alone fails to reduce the hernia. Recurrences are rare (Giles *et al.* 1953, Berens 1963, Jones 1964).

The first successful operation was performed in 1888. The mortality is still high but has declined over the years to around 20 per cent.

Three rules concerning paraduodenal fossae and hernias should be kept in mind.

1. In general, asymptomatic paraduodenal hernia found as an incidental finding on exploration for another cause should be left alone.

2. Avoidance of injury to any major blood vessel, should incision of the hernia sac be necessary.

3. Closure or enlargement of hernia sac orifice in symptomatic cases, if possible.

Summary

1. Paraduodenal hernias may contain varying lengths of entrapped small bowel, as shown by this case.

2. Less than subtotal entrapment of small bowel has not been stressed in the literature.

3. Classification of less than subtotal paraduodenal hernia is difficult, particularly when the fossa is distorted by dilated entrapped bowel.

Department of Surgery
Piedmont Hospital

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HIGHLIGHTS OF COUNCIL MARCH 6-7, 1971

Finance: Voted these budget adjustments: Decreased Past-President Travel \$558.50, AMA Delegates' Travel \$550.00, Speakers' Travel \$300.00; Increased Office Travel \$808.50, President's Travel \$600.00; Voted \$600.00 contribution to MAG Foundation from pension payments. Instructed the Finance Committee to include a \$2,500.00 contribution to the Health Careers Council of Georgia in the 1971-72 budget; authorized hardship exemptions from 1969 additional dues when requested by County Societies.

Communications: Authorized a 3-month trial of cassette recordings from MAG Headquarters to County Societies.

Appointments: Approved submission to Governor Carter of Third District Board of Health nominations in alphabetical order.

County Societies: Approved the merger of Polk County Medical Society with Floyd County Medical Society to form the Floyd-Polk-Chattooga County Medical Society.

Podiatrists: Endorsed Committee on Professional Conduct and Medical Ethics' recommendation opposing hospital staff privileges for Podiatrists.

Licensure: Voted to begin steps toward establishment of a State Disciplinary Board. Voted to request Gubernatorial veto of Alien Licensure Bill.

Insurance: Approved the following table of 1971-72 rates for member Professional Liability coverage recommended by the Committee on Insurance and Economics: (Class I) \$213, (Class II) \$284, (Class III) \$666, (Class IV) \$777, (Class V) \$875. Voted commendation for Chairman William W. Moore, Jr., M.D. Adopted a comprehensive Blue Cross-Blue Shield Plan for MAG members, families and employees.

State Planning Commission: Adopted plans for letters to the Governor urging MAG selected physicians be appointed to the new Commission.

Medicaid: Authorized MAG and Foundation Presidents to communicate with the State Board of Health on Medicaid Review mechanisms.

Foundation: Instructed Staff to include a Foundation report on each agenda.

Next Meeting: 2:00 p.m., Wednesday, May 12, 1971, Mariott, Atlanta.

Blood gas studies are recommended as a part of the routine evaluation and management of cases where pulmonary embolism or incipient respiratory insufficiency are suspected.

Usefulness of Arterial Blood Gases in Obscure Diagnosis

**RAUL E. SORIA, M.D., WILLIAM E. MITCHELL, JR., M.D., and
JOHN E. SKANDALAKIS, M.D., Ph.D., F.A.C.S., Atlanta**

*"O Lord, we thank Thee for the Oxygen Gas; we thank Thee for the
Hydrogen Gas; and for all gases."*

John Wheelock (1754-1817)

IN THIS COMMUNITY HOSPITAL of approximately 300 beds we have become increasingly concerned with pulmonary problems in surgical patients. The importance of pulmonary emboli as a leading cause of death has been shown by a recent study at the Peter Bent Brigham Hospital, and by the estimate that emboli cause approximately 50,000 deaths each year in the U.S.^{6, 24} Another type of pulmonary problem, acute respiratory failure, is also too frequent in the post-operative patient.

Massive pulmonary embolism was described by Laennec in 1819 as "pulmonary apoplexy."¹⁵ Cruveilhier subsequently observed that the arterial branches in the pulmonary tree, in such cases, were filled with clot, and both he and Laennec speculated that the clots arose *in situ* in the pulmonary arteries.⁷ Virchow promoted the concept of embolic origin of the clots and William Welch later pointed out that embolism could occur without infarction.^{25, 26, 30}

Thoracic surgeons have repeatedly demonstrated that a pneumonectomy is usually tolerated quite well in normal man, and in experimental animals occlusion of the pulmonary artery is accompanied by few cardio-dynamic changes.^{8, 9, 19, 20} The presence or absence of underlying cardio-respiratory disease plays a large role in determining the individual's response to occlusion by pulmonary embolus.^{2, 3, 5, 17} Reflexes have been invoked to explain the variable cardio-dynamic disturbances seen after pulmonary emboli, but there is little convincing experimental evidence.^{8, 10} Experimentally there is a rapid absorption of clots lodged in the pulmonary arteries and within 21 to 28 days there is usually little or no remaining evidence of their presence.^{1, 11, 12, 16, 22} As one would expect, when the pulmonary artery or one

of its branches is occluded, there is a cessation of gaseous exchange in the area served although ventilation usually remains normal for some time.⁴

At the alveolar level in the normal lung there is usually rapid equilibration of carbon dioxide between the alveoli and the pulmonary capillaries, across the alveolar capillary membrane. Therefore, in the normally ventilated and normally perfused lung, the arterial PCO₂ generally directly reflects the alveolar PCO₂ and is thus an excellent index of alveolar ventilation.¹⁸ Because occlusion of the pulmonary artery prevents release of CO₂ in the alveoli, the alveolar PCO₂ will be much lower than normal and there will be a discrepancy between the alveolar PCO₂ and the arterial PCO₂ in such patients. It has been suggested that measure of the alveolar CO₂ tension and a comparison with the arterial blood CO₂ tension might be an indicator of the ventilated but unperfused lung, such as one would see with a pulmonary embolus. In practice this has not been particularly useful due to technical problems. It was also discovered, that even patients with normal chest x-rays and no previous lung disease have a consistent hypoxia associated with pulmonary embolism. This agrees with the clinical observation that patients with severe pulmonary embolism are often cyanotic. Even in the absence of cyanosis, however, a consistent lowering of the PO₂ is demonstrable in the blood. In many cases, diagnosis of pulmonary embolism is obvious, but in others it can be equivocal. The only clue may be an unexplained mild hypoxia. Once suspected, the diagnosis can be confirmed by a lung scan or by pulmonary arteriography.^{24, 27, 28, 29} It must be emphasized that patients with congenital heart disease, right-to-left

shunts or other underlying lung disease may also demonstrate distortions of the blood gases making interpretation considerably more difficult. Hypoxia in pulmonary embolism has been studied in some detail; since no single explanation seems adequate, more than one mechanism may be in operation. The supposed mechanisms include, first, a change in the ventilation perfusion ratio; a second is a localized pulmonary edema with a secondary diffusion block at the alveolar capillary membrane. Since oxygen diffuses a great deal more slowly than CO₂, it is possible to have a hypoxia and a lowered PO₂ without a rise in the arterial PCO₂ if the patient hyperventilates. A third mechanism is a right-to-left shunt through a persistent foramen ovale, or through collaterals between the azygos and the pulmonary venous system, presumably enhanced by increased pressures on the right heart. Which of these mechanisms is primary has not yet been settled, but of particular clinical importance is the observation that in experimental animals, after a moderate size embolus, hypoxia can be reversed by positive pressure ventilation using room air. When additional emboli are introduced, arterial oxygenation can be maintained only by a combination of positive pressure and high concentrations of oxygen.^{14, 19, 23}

tion rub, or hemophysis, the clinical diagnosis was fairly evident but the confirmatory blood gas analysis was reassuring.

The second case was a 56-year-old male who underwent repair of a massive ventral hernia. Post-operatively he developed restlessness, respiratory distress and tachycardia; three days later he had a gas analysis showed hypoxia; a subsequent lung scan confirmed the diagnosis of pulmonary embolus which was satisfactorily treated with tracheostomy, oxygen, positive pressure ventilation and anticoagulants. This was a complex case and it is probable that repeated pulmonary emboli would have proved fatal, had not the blood gas analysis prompted investigation with a lung scan which led to appropriate therapy.

The third case was a 57-year-old woman who fell in her bathtub and fractured the right lobe of her liver. During the operation she suffered cardiac arrest but was satisfactorily resuscitated. Post-operatively she initially appeared to do well but gradually became restless, confused and finally hypotensive. Though she had bilateral, fluffy pulmonary infiltrates, she was never cyanotic, and we were surprised when her blood gas studies showed a marked hypoxia. A tracheostomy was performed; she was put on positive pressure ventilation and she immediately improved. In retrospect, it was obvious that

CASES OF SEVERE HYPOXEMIA WITH HYPOCAPNIA

Pt.	Age	Sex	Surgical Procedure Before Resp. Failure	Clinical Features	Lowest PO2/PCO2	Result
N.B.	42	F	Patellectomy	Restless; fast pulse	65/37	Recovered
L.G.	56	M	Ventral hernia repair	Restless; fast pulse	37/21	Recovered
M.W.	57	F	60% liver resection	Restless; fast pulse	30/41.5	Recovered

Case Reports

We have selected several recent cases which illustrate some of the situations in which blood gas analysis may be useful.

The first was a 42-year-old woman who had undergone removal of her right patella, followed by application of a long leg cast. Two weeks later she was seen with pleuritic right chest pain. The chest was clear; the x-ray showed only slight elevation of the right hemi-diaphragm. Blood gases, however, showed a normal pH, slightly lowered PCO₂, presumably reflecting hyperventilation, and a PO₂ of 65, the normal being 90-100. Only after several days could a wedge shaped infarction be demonstrated on the chest x-ray. She was treated with anti-coagulant therapy, and 10 days later her PO₂ and PCO₂ were essentially normal. Despite the nondiagnostic chest x-ray, and the absence of cyanosis, fric-

tion rub, or hemophysis, the clinical diagnosis was fairly evident but the confirmatory blood gas analysis was reassuring.

the severe metabolic stress imposed by the 60 per cent hepatectomy, massive transfusion and cardiac arrest was aggravated by insidious but progressive respiratory insufficiency due to what proved to be a pseudomonas pneumonia. This had become quite cardiac arrest from which he was resuscitated. Blood advanced despite the absence of cyanosis. Its detection was made more difficult by the presence of moderate anemia and a profound jaundice. We were able to treat her pneumonia with appropriate antibiotics. She gradually improved and was ultimately discharged in good condition. It seems likely that had blood gases not been analysed, she would have died, since clinically it appeared that her ventilation and oxygenation were quite adequate.

Summary

The usefulness of blood gas studies in management of acid-base balance problems is well estab-

**PIEDMONT HOSPITAL
DEPARTMENT OF SURGERY**

PATIENT: L.G.

HOSP. NO. 342-288

8/20—Ventral Hernia Repair
8/23—Cardiac Arrest & Tracheostomy
9/28—Tracheostomy Discontinued

	8/23	8/25	8/26	8/27	8/28	8/29	8/30	8/31	9/5	9/14	9/28
pH	7.44	7.55	7.56	7.65	7.68	7.56	7.50	7.50	7.53	7.41	7.54
PO2	57	74	80	55	37	59	47	159	47	68	66
PCO2	39	37	36	38	21	41	39	43	34	33	30

lished and blood gas data is often essential in providing optimum care for the critically ill patient with cardio-pulmonary problems. Our first patient demonstrated a classic mild hypoxia, with a small pulmonary embolus. Our other two cases illustrate the usefulness of blood gas studies in critically ill patients with a multiplicity of problems. In both of these instances the information provided by the blood gas analysis gave prompt recognition of the problems, which might otherwise have been fatal. We recommend utilization of blood gas studies as part of the routine evaluation and management of all cases of suspected pulmonary embolism and incipient respiratory insufficiency.

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Radical Ligation in Two Cases of Arteriovenous Fistula

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JOHN E. SKANDALAKIS, M.D., Ph.D., F.A.C.S., *Atlanta*

LARGE ANOMALOUS CONNECTIONS between arteries and veins have been called arteriovenous fistulae, arteriovenous aneurysms, cirroid aneurysms, and arteriectasias (Liebold, et al. 1968, Benson, et al. 1965, Liggins 1964). We prefer the term fistulae because it emphasizes the physiological effect of the lesions on the circulation.

Arteriovenous fistulae may be congenital or acquired. Congenital fistulae represent persistent portions of undifferentiated, embryonic vascular loops (Cross, et al. 1958). They appear to be more frequent in women (Kolesnikova, et al. 1970); large pelvic fistulae may be associated with difficulties in labor and delivery (Benson, et al. 1965).

Acquired fistulae are usually the result of penetrating injuries by stabbing, or by high velocity projectiles (Hufnagel and Conrad 1962). Occasionally they result from surgical trauma. Fistulae may also follow rupture of an arteriosclerotic aneurysm into an adjacent vein to which the aneurysm had become adherent.

An untreated fistula is a left to right shunt placing a load on the heart which may end in heart failure. Treatment by ligation of the vessels to the fistula involves the risk of ischemia and necrosis of structures distal to the lesion. In two cases described here, extensive ligations were tolerated by the patient and there was no evidence of vascular deprivation.

History

While arteriovenous connections were said to be described as early as the first century A.D. by Rufus of Ephesus, their pathological significance was not understood until William Hunter published his observations on two cases in 1762. It was not until 1946 that Pemberton and his colleagues reported the first successful closure of an arteriovenous fistula involving major vessels within the abdomen. In the

same year, Elkin reported successful repair of a fistula between the external carotid artery and the internal jugular vein.

Less than a dozen cases of arteriovenous fistula in pelvic vessels have been reported, while over 200 cases in the extremities are known. The legs are affected twice as often as are the arms.

Case Report

A 33-year-old white female, G2, P2, weighing 100 pounds was found to have multiple arteriovenous fistulae on the left side of the pelvis.

Two months after her last delivery, 12 years ago, she had undergone an operation for repair of the fistula. Four months later, a second operation for the repair of the same fistula was required. About one year after her delivery, she had a total abdominal hysterectomy with removal of the left ovary and tube, together with ligation of vessels still supplying the fistula. Since her third operation she was asymptomatic until two weeks prior to the present admission when she complained of persistent right lower quadrant pain and tenderness without fever, nausea or vomiting.

On physical examination, blood pressure was 100/60; the heart was not enlarged, and there were no murmurs or thrills. The pulse was regular at 82/min. There was tenderness without rebound or guarding in the hypogastric area and the right lower quadrant of the abdomen.

There was a loud bruit in the left lower quadrant and over the left femoral vessels. Pelvic examination revealed a left adnexal mass 4-5 cm. in diameter with appreciable pulsation. Some fullness with tenderness was found in the right adnexal region but no definite mass was felt. The pulse in the lower limbs sounded normal. There was no deformity or edema.

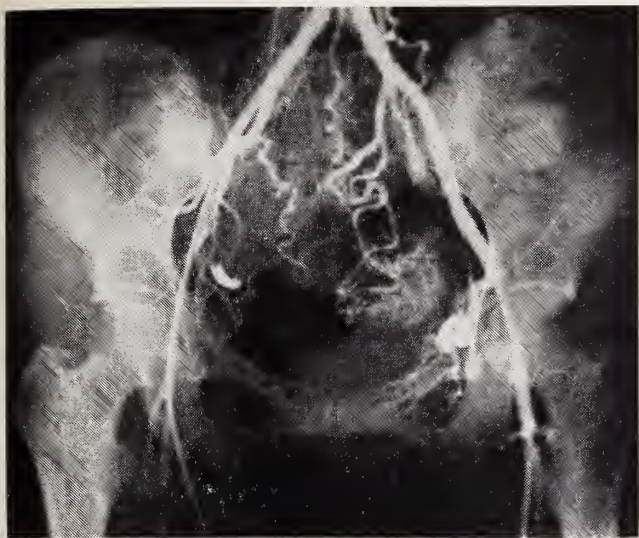


FIGURE 1

Case 1. Pre-operative x-ray taken during arterial phase of vascular visualization of the fistula.

Laboratory studies were within normal limits.

Arteriograms confirmed the diagnosis of arteriovenous fistula. A retrograde Seldinger aortogram was carried out through the right femoral artery and multiple, rapid sequence films of the pelvic area showed a large, irregular arteriovenous fistula or aneurysm measuring 11 x 6 cm. on the left side of the pelvis (Figures 1 and 2).

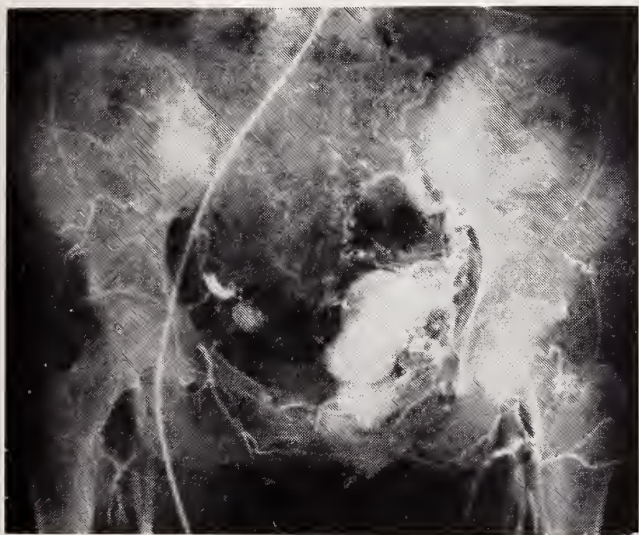


FIGURE 2

Case 1. Pre-operative x-ray taken during venous filling phase of vascular visualization of the fistula.

At least five arteries supplied the malformation: 1) a branch from the inferior mesenteric artery (probably the superior hemorrhoidal artery); 2) a second branch, the sigmoid artery; 3) the middle sacral artery; 4) a branch from the left femoral artery and 5) a branch from the left hypogastric artery.

Procedure

The surgical procedure consisted of ligation and division of the superior hemorrhoidal, sigmoid, mid-

dle sacral, and both hypogastric arteries as well as the inferior mesenteric, left internal iliac and the ascending branch of the left fourth lumbar veins. In addition, the appendix was removed and a left lumbar sympathectomy performed because of spasm of the iliac and femoral arteries. During the operation, arteriograms were taken. Sigmoidoscopy following the ligations showed no ischemic changes in the lower colon. The patient was discharged 12 days after the operation.

About four weeks later the patient was involved in an automobile accident and re-admitted to the hospital for multiple lacerations, contusions, and a rib fracture. Arteriograms showed successful ligation of arteries to the fistula. Delayed films showed venous filling of the dilated and tortuous vessels of the fistula (Figure 3).

Case No. 2

A 54-year-old white female, G4, P3, was observed to have a pulsating mass on the left foot three to four months prior to admission. There was a history of cramps in the left leg when in bed and occasional swelling of the leg. Numbness or tingling of the leg was denied and there was no history of phlebitis or injury. For years she had noted that the left foot was warmer than the right. She complained of "migraine headaches" with nausea and vomiting which occurred twice a week.

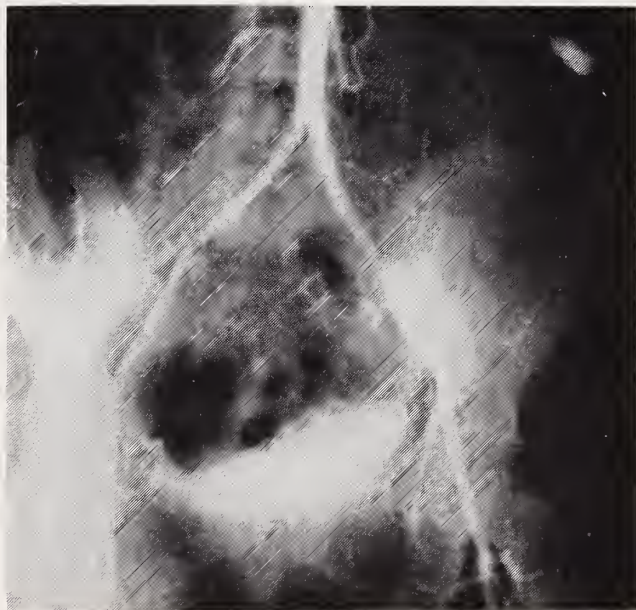


FIGURE 3

Case 1. Postoperative x-ray showing the absence of arteries feeding the fistula. Compare with Figure 1.

On physical examination, blood pressure was 140/10 and pulse was 110/min. The heart beat was regular without murmurs. There was a continuous thrill and murmur on the dorsum of the left foot which could be suppressed by a tourniquet around the ankle. Many dilated superficial veins were present.

Laboratory studies were within normal limits.

Arteriograms showed multiple arteriovenous communications with a racemose collection of large vessels over the entire dorsum of the foot. These vessels were supplied by arterial branches from the peroneal and the anterior and posterior tibial arteries (Figure 4).



FIGURE 4

Case 2. Pre-operative x-ray of arteriovenous fistula of the foot.

Surgical procedure consisted of ligation of the three arterial branches and all of the venous communications with the fistula. When she was discharged her blood pressure was 130/80 and there was no murmur or palpable thrill on the foot. Her "migraine headaches" have not recurred.

Anatomical Considerations

One will wonder about the extensive ligations of the responsible vessels in these two cases. How has the blood supply been preserved?

In the first case, survival of the pelvic organs can be explained only by normal collateral circulation in addition to that which develops over a period of time in the presence of a fistula. There are eight major

pathways of collateral circulation following bilateral hypogastric ligation:

- 1) Uterine a. with ovarian a. from the aorta
- 2) Middle hemorrhoidal a. with superior hemorrhoidal a. from the inferior mesenteric a.
- 3) Obturator a. with inferior epigastric a. from the external iliac a.
- 4) Inferior gluteal a. with circumflex and perforating branches of the deep femoral a.
- 5) Iliolumbar a. with lumbar a. from the aorta
- 6) Lateral sacral a. with middle sacral a. from the aorta
- 7) Anastomoses between vessels of the bladder wall and the abdominal wall
- 8) Anastomoses between internal and external pudendal arteries

In the second case the collateral circulation came through the medial malleolar and lateral malleolar networks as well as medial and lateral arcades served by the perforating branch of the peroneal artery just above the ankle.

Symptoms

Arteriovenous fistulae are not always associated with symptoms. The lesion may be discovered during the course of a physical examination, or the patient may hear or feel a buzzing sensation in the region of the fistula. Some patients notice dilated veins in the region of a lesion or an alteration of warmth and color of the affected hand or foot. Sometimes, medical aid is sought only after the development of cardiac symptoms such as palpitations, tachycardia, dyspnea, or frank heart failure. In rare circumstances, the presenting symptoms are the chills and fever resulting from subacute bacterial endarteritis at the site of the fistula (Nakano and De Schryzer 1964).

Repeated auscultation of injured areas should lead to earlier diagnosis and treatment of arteriovenous fistulae (Berner, et al. 1967). Tice, and his colleagues (1963) suggest that one should suspect an arteriovenous fistula with varicose veins in children and young adults, especially varices at unusual sites or of sudden onset. Small arteriovenous fistulae are present in most patients with varicose veins (Guis 1960). A painful hemorrhagic ulcer may be secondary to an arteriovenous fistula.

A definite diagnosis of arteriovenous fistula should present: a continuous, machinery-like murmur heard with the stethoscope placed over the lesion, visible venous dilatation or swelling to an area, a drop in pulse rate following application of pressure over the fistula or proximal to it (Branham-Nicoladoni sign). Confirmation of the diagnosis and visualization of the fistulae is obtained by arteriography.

Surgical Considerations

It has been known for many years that excision of an arteriovenous fistula does not have the same effect on the circulation as ligation of normal arteries and veins at the same site (Robertson, et al. 1950). Fortunately for the surgeon, such a fistula causes the rapid development of an extensive collateral circulation (Matas 1923). The mechanism of this response which requires a few months to reach its maximum is still largely unknown.

The goal of treatment is to eliminate the fistula and to restore normal arterial flow to distal structures with as little ischemia as possible. This may be achieved in the case of small fistulae by simple excision with ligation of small unimportant arteries and veins. Large fistulae involving major blood vessels are usually a serious and sometimes an insuperable problem.

Matas (1923) showed years ago that when the supplying artery is ligated proximal to an arteriovenous fistula, the blood from collaterals entering the artery distal to the fistula flows proximally in the distal segment and is diverted to the vein through the fistula, thus depriving distal tissues of arterial blood. If distal ligation only is performed, the amount of blood passing through the shunt is increased and the strain on the heart is greater.

Ligation of the four ends of the fistula, proximal and distal artery, and proximal and distal vein, rarely produces severe ischemia if the ligations are made about three months after the appearance of the fistula. Nonetheless, because the main arterial channel is interrupted, there may be some disability following this procedure in some anatomical locations. The two cases reported here were probably both congenital, and hence their collateral circulation was developed to its maximum.

Summary

1) Two cases of probably congenital arteriovenous fistula, one in the pelvis and one in the foot, are presented.

2) Despite extensive ligations both patients suffered no serious ischemia of distal structures.

3) The anatomical and surgical considerations of the treatment of such lesions are discussed.

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Advances in Nuclear Medicine— Radioisotopes in Evaluation of Neurological Disorders

MENARD IHNEN, M.D. and POMEROY NICHOLS, M.D., Augusta

SINCE THE REPORT OF BRINKMAN, et al.,¹ the value of radioisotope techniques in the detection of brain tumors has become familiar to most physicians. The experience which has been obtained since the early reports has resulted in some modifications of these examinations; these modifications, together with refinement of interpretation, have made the examinations valuable for the detection of other central nervous system lesions in addition to brain tumors.² In addition, new examinations have been added to evaluate cerebrospinal fluid dynamics.³

It is the purpose of this paper to provide a brief outline of the current state of this diagnostic field, to list the indications for radioisotope examinations in neurological disorders, to discuss the lesions which may be detected, and to mention some of the limitations of these techniques.

Examinations in Current Use

STATIC VERSUS DYNAMIC EXAMINATIONS: In earlier studies, brain tumors were detected by the use of scanners. After administering a radioactive substance to the patient, a moving detector was used to locate the site of abnormal deposition. At least one hour should elapse between the administration of the radioisotope and the beginning of the examination to obtain the most favorable ratio between isotope concentration in the lesion to general body background. This is a *static* examination to detect altered blood brain barrier permeability; the static examination continues to be the single most important, most productive examination utilizing radioisotopes in neurological disorders.

In the past few years, a different kind of detector has permitted the visualization of *dynamic* processes. This detector is the Anger camera which is a stationary detector in contrast to the scanner which is a moving detector. Since the camera has a rela-

tively large field and since it is stationary, one can follow the movement of an injected radioisotope by obtaining images of the region in sequence. Thus, one can obtain information about *altered vascular blood flow* by utilizing the camera.⁴ The camera is also quite satisfactory for the static examinations mentioned previously. A comparison of the static and the dynamic examinations is outlined in Table I.

Dynamic examinations require that each image in the sequence be obtained in a short period of time. As a result, the choice of isotope becomes important since one must give large quantities of the selected radioisotope without exposing the subject to unnecessary radiation. Technetium (^{99m}Tc) is an isotope which is very well suited for this purpose. The physical half-life of six hours permits one to use large doses without risk. The pharmaceutical industry is to be commended for rapidly developing and marketing these radioisotopes in a form which permits their use in almost any general hospital in an urban community.

Recently, study of spinal fluid dynamics or *scintiscintigraphy* has been investigated intensively. High specific activity serum albumin tagged with a radioactive substance is injected into the lumbar subarachnoid space³ or into the cerebral ventricles.⁵ Although this is a dynamic examination, movement is quite slow. Flow is demonstrated by the study of images obtained over a period of two or three days. The patterns and rates of flow provide important functional information in the evaluation of various types of hydrocephalus, focal ventricular or subarachnoid block and focal sites of dilatation of the subarachnoid space.

Lesions Detected

Static brain scans or scintiphotos are quite effective in detecting poorly differentiated gliomas or meningiomas, the most common primary intracranial

TABLE I
COMPARISON OF STATIC AND DYNAMIC RADIOISOTOPE CRANIAL EXAMINATIONS

	Static	Dynamic
Condition Detected:	Altered Blood-Brain Barrier Permeability	Altered Vascular Blood Flow
Lesion Detected:	Most Brain Tumors Intracranial Metastasis	Decreased Carotid Artery Blood Flow Decreased Blood Flow in Major Intracranial Arteries Differentiation of Infarct From Tumor Vascular Malformations Some Carotid Artery or Intracranial Arterial Aneurysms
	Cerebral Infarcts (after 7-10 days) Some Vascular Malformations Brain Abscess	
Lesions Not Detected:	Subdural Hematoma, Occasionally Some Cranial Bone Lesions Meningitis, Occasionally Subarachnoid Hemorrhage, Usually	Small Cerebral Infarct or Region of Ischemia Most Aneurysms of Intracranial Arteries Subdural Hematoma, Subarachnoid Hemorrhage, Intracerebral Hemorrhage
Radioisotope Used:	Most Aneurysms of Intracranial Arteries ^{99m}Tc , ^{197}Hg -Chlormerodrin, ^{203}Hg -Chlormerodrin, rarely others	^{99m}Tc
Detector System Used:	Scanner or Radioisotope Camera	Radioisotope Camera

tumors (Figures 1, 2). Other brain tumors can be detected as well although the incidence of false negative examinations may be slightly higher. Cerebral metastases are readily detected and brain abscesses usually result in high concentration of the injected radioisotope.

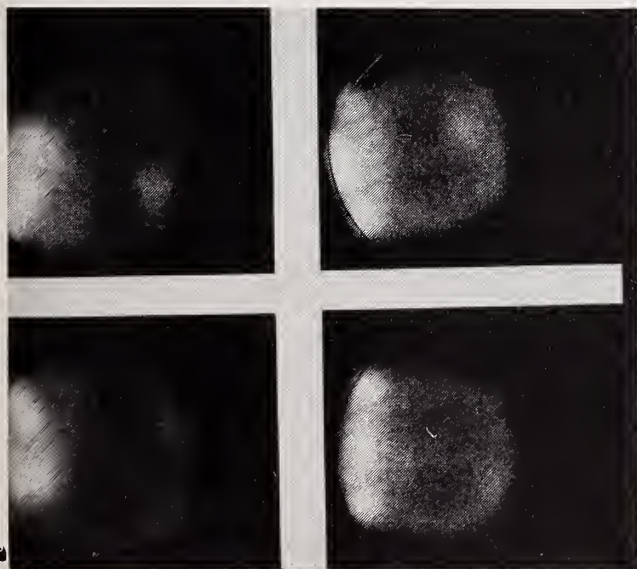


FIGURE 1

Static brain scintiphotos showing well defined heavy concentration of radioisotope in right parasagittal region. From left to right, top row: anterior and posterior images; bottom row: right lateral and left lateral examinations. Surgical exploration revealed a meningioma which was completely removed.

Not all sites of heavy deposition of radioisotope are neoplasms, however. In some patients there is heavy concentration in the choroid plexus (Figure 3). Although cerebral infarcts do not usually show increased concentrations in the first week, heavy

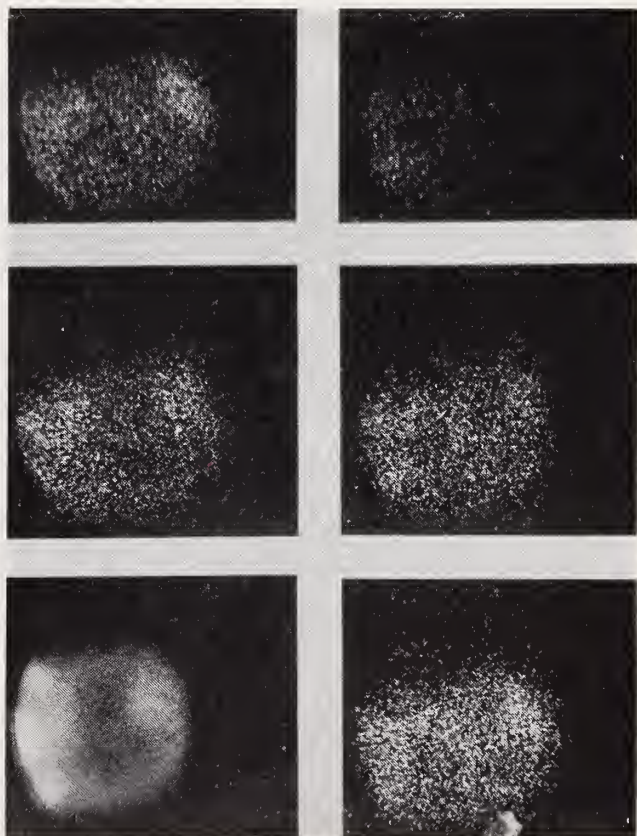


FIGURE 2

Blood flow scintiphotos of patient shown in Figure 1. Anterior examinations from left to right, top to bottom at 9, 12, 15, 18 and 21 seconds after injection of radioisotope into an arm vein. Compare with anterior static examination in lower right and note heavy concentration of radioisotope in region of lesion during arterial perfusion. The vascularity of the lesion suggests tumor or inflammation rather than infarct.

deposition may be seen after that time (Figure 4); in some cases, the heavy concentration of radioisotope may suggest tumor and the dynamic studies

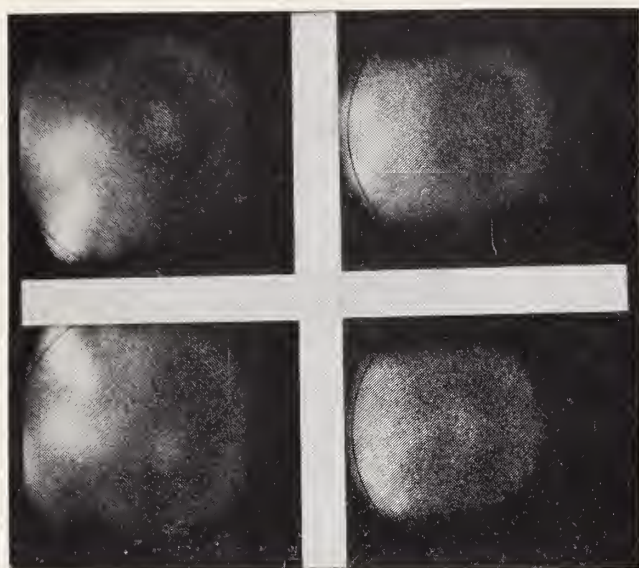


FIGURE 3

Well localized, heavy accumulation of radioisotope in choroid plexus, a normal finding in some patients. From left to right, top to bottom: anterior, posterior, right lateral and left lateral static examinations.

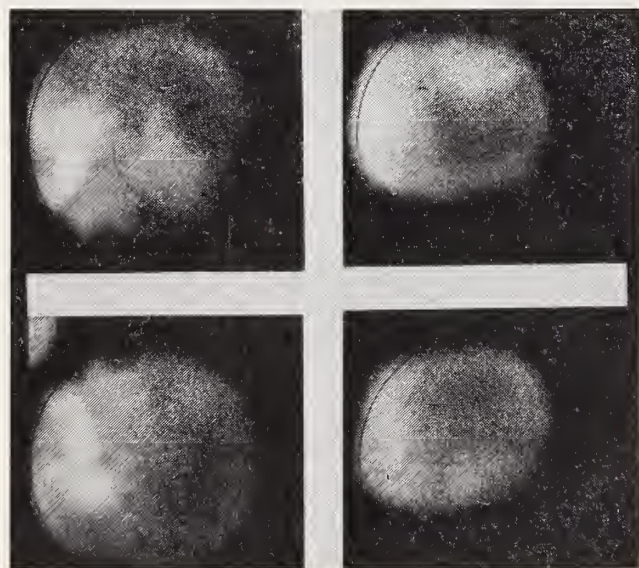


FIGURE 4

Large peripheral, right fronto-parietal area of heavy radioisotope deposition in a 62 year old with a history of left hemiplegia beginning five days before examination. From left to right: anterior, posterior, right lateral and left lateral static brain scintiphotos. Right carotid arteriogram was normal and it is assumed that the lesion is a cerebral infarct.

described below are employed in differential diagnosis (Figures 2, 6).

One cannot use these examinations to exclude subdural hematoma, intracranial aneurysms, subarachnoid hemorrhage or intracerebral hematoma and we wish to emphasize this point. It is true that one may see abnormal radioactivity deposited in some cases of subdural hematoma, but no changes are seen in many other cases. In suspected sub-

dural hematoma, the use of diagnostic ultrasound to detect midline deviation, combined with the radioisotope examinations, has been of great help (Figure 5).

The dynamic blood flow examinations described previously are very important in more precise characterization of intracranial lesions. Thus, cerebral infarcts which are seen as abnormal sites of radioisotope deposition in static examinations tend to be sites of ischemia in the dynamic examinations. In contrast, many tumors are sites of increased blood flow so that the differentiation between cerebral infarct versus brain tumor can be accomplished in many cases (Figures 1, 2).

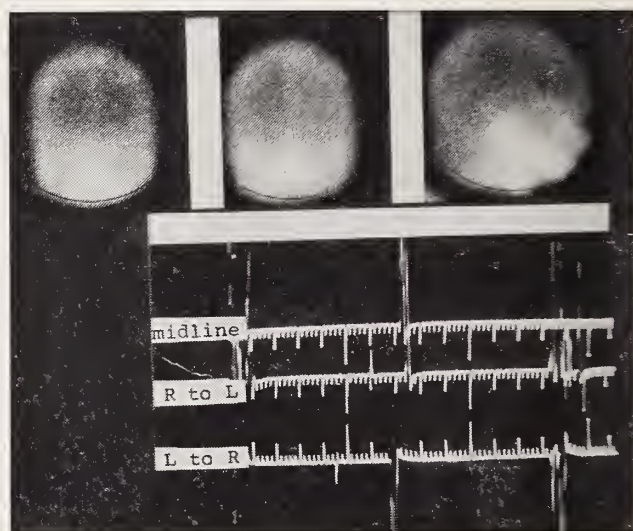


FIGURE 5

Normal static brain scintiphotos (from left to right: anterior, posterior, right lateral, left lateral examination) from young man with persistent headache following head trauma while playing football. Neurological examination was normal. Ultrasound record shown below the scintiphotos indicated right to left midline shift. Following carotid arteriography, a large right subdural hematoma was evacuated.

Vascular malformations are examples of lesions which may be inconspicuous in static examinations; however, most of these lesions "glow" as sites of radioactivity in dynamic examinations illustrating the value of dynamic examinations in differential diagnosis (Figure 6).

The yield in major carotid or cerebral artery stenosis or occlusion is sufficient to make dynamic examinations worthwhile although there is some difference of opinion in published reports regarding the capability of detecting such lesions. Time involved is a major factor to consider if one decides to add the dynamic examinations to brain studies as a routine procedure.

Indications for Radioisotope Examinations

Almost all of the patients which we have examined have been referred by well qualified neurosurgeons, psychiatrists, neurologists, or internists.

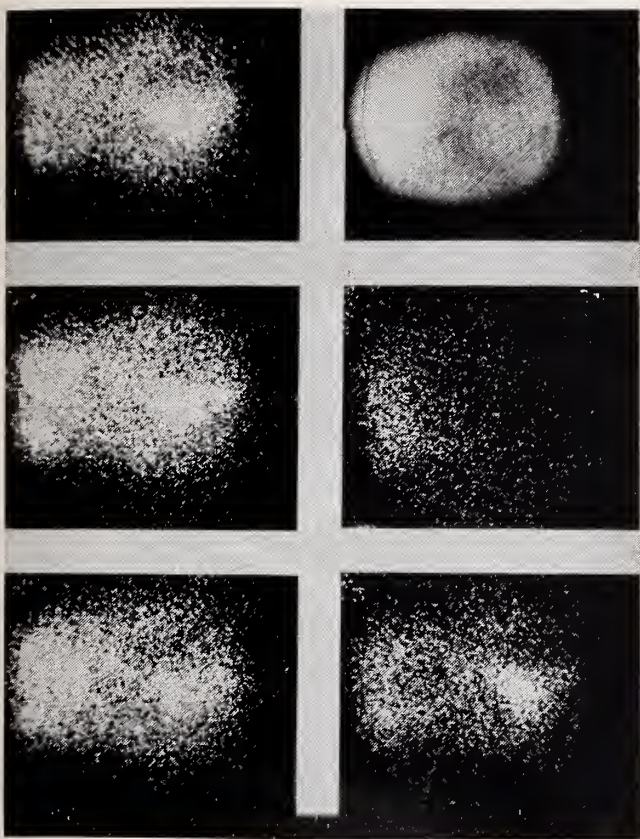


FIGURE 6

Studies performed on a 44 year old woman admitted to psychiatric service from headaches. Upper left: static anterior scintiphoto indicating large abnormal left parasagittal concentration of radioisotope. From left to right, top to bottom: dynamic blood flow scintiphotos in same position at 3, 6, 9, 12, and 15 seconds after injection of radioisotope in an arm vein. Dynamic scintiphotos demonstrate a highly vascular lesion. Arteriography revealed an arteriovenous malformation.

Although these patients have been examined by experienced specialists, the frequency of unsuspected lesions is significant. Certainly, one cannot depend on the history or neurological examination to exclude all serious intracranial lesions. Occasional patients with severe psychiatric disorders have had unsuspected tumors or other mass lesions. In many cases, the lesions found were meningiomas which can be removed quite effectively.

With increasing experience, it has become evident that each of the available diagnostic procedures including radioisotope examinations, diagnostic ultrasound, arteriography, and pneumoencephalography add information which leads to greater confidence in preoperative evaluation. This is particularly true for the abnormal deposition of radioisotopes which is a positive reflection of a lesion in contrast to displacement of blood vessels or alteration of ventricular form in some of the other procedures.

As noted previously, risk and discomfort are insignificant in the radioisotope examination. No preparation is required, and the examinations are easily accomplished on an out-patient basis. Cost is a consideration when the examinations are used as

a screening basis. However, by these simple and safe techniques, one must consider that the results obtained, normal or abnormal, may well result in the avoidance of subsequent elaborate, costly and even risky diagnostic procedures.

University Hospital 30902

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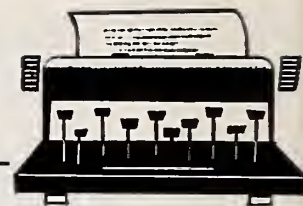
19th Annual Meeting

AMERICAN COLLEGE OF OBSTETRICIANS GYNECOLOGISTS

San Francisco, California

May 3-6, 1971

For further information on this clinical meeting, contact: Donald F. Richardson, 79 West Monroe Street, Chicago, Illinois 60603.



Surgical Education at Piedmont Hospital

AMERICAN SURGICAL EDUCATION is now undergoing a period of great uncertainty and change, due in large part to the remarkable proliferation of "third party" insurance plans. The "service" patients who played so vital a part in the training of many of America's leading surgeons are rapidly disappearing.

This has necessitated a painful reorientation on the part of those training programs whose major attraction for surgical residents has been the seemingly inexhaustible supply of indigent patients. Whether the overall quality of surgical training will deteriorate because of this change is an unanswerable, though important and much-debated, question. The fact remains, however, that the disappearance of the "service" patient has eliminated a major advantage of university programs, and provides a unique opportunity for *private* hospital programs to assume a major role in the surgical education of the future.

University affiliation will continue to be useful in many instances, since the benefits of having a mixture of medical students, house officers, faculty, private physicians, and patients is usually mutually advantageous to all concerned. Many of our better private hospitals already have well-established programs integrating progressive responsibility for the surgical residents into a smoothly functioning system of first-class care of predominately private patients. Properly approached in a matter-of-fact fashion, private patients not only understand but usually welcome the involvement of residents in their care so long as they are confident of the constant presence and supervision of their private physician. It should be obvious that any violation of this confidence is intolerable, and will result in the rapid collapse of the entire system. Patients must be accurately informed as to who is doing what, and the use of subterfuge or half truths is both foolish and unethical. The initial patient resistance sometimes encountered as this approach is introduced is understandable but can be quickly overcome if the private surgeon has the confidence of his patient and presents the situation in a thoughtfully reasoned, matter-of-fact manner. Only rarely will a truly uncooperative patient be encountered, and in such a situation the surgeon has no alternative to a graceful capitulation.

In an occasional instance, a progressive private hospital's governing body and administration (with the active support of the medical staff) may be so cognizant of their responsibility to the community and of the importance of improving surgical training that they are willing to defray the expenses of significant numbers of patients without third party coverage who wish to be cared for on the residents service at no cost. As an example, admission via the Community Service Program to the Residents Service at Piedmont Hospital is easily accomplished on referral from physicians or social workers, and is simplified by our requiring no forms of any sort from patients stating their inability to pay. No embarrassing "means checks" are carried out, since our purpose is to *include* rather than *exclude* as many patients as possible. Surgical care and follow-up are comprehensive, but great care is taken to facilitate the return of the patient to his primary physician who also receives a letter from the resident describing the care rendered to the patient.

Since the Piedmont Hospital system of integrated service-private patient training is well established and supervised by enthusiastic, experienced surgeons certified by the American Board of Surgery, we feel that we and other hospitals like us are already well along in our development of a system which may well dominate the training of the next generation of surgeons in this country.

Finally, it is a source of great pride and satisfaction for practicing surgeons to be able to participate in a program which provides unquestioned advantages for our patients, house officers and colleagues, and at the same time is a demonstrated service to our community.

*John T. Akin, Jr., M.D., Charles S. Jones, M.D.,
Stewart M. Long, M.D., Duncan Shepard, M.D.,
John E. Skandalakis, M.D., and
William E. Mitchell, Sr., M.D., Atlanta**

** Senior Attending Surgeons, Piedmont Hospital, Atlanta, Georgia.*

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MARCH 6, 1971

Appointments: Medical Review and Negotiating Committee: William R. Edwards, Jr., M.D., Atlanta (Otolaryngology); Hans Peters, M.D., Columbus (Pathology). Fourth District, GRMP Advisory Group: Freeman Simmons, M.D., Representative; Frank Morgan, M.D., Alternate. Eighth District, GRMP Advisory Group: F. G. Eldridge, M.D., Valdosta (Alternate). Third District, State Board of Health, Nominations to Georgia Governor: Robert C. Garrett, M.D., Vienna; Floyd C. Jarrell, Jr., M.D., Columbus; James H. Sullivan, M.D., Columbus.

Committees: Designated an Ad Hoc Committee, chaired by John T. Mauldin, M.D., Atlanta, to study creation of a Georgia Association of Health Professions, to report to the April meeting of Executive Committee.

Officers: Voted to recommend to Council that the offices of Secretary and Treasurer remain as presently constituted.

Peer Review and Foundation: Voted to transfer to the Georgia Medical Care Foundation, Inc., all authority and responsibility of the Committee on Medical Review and Negotiating, except Peer Review Policy and

Appeal. The Executive Committee changed the name of the Committee on Medical Review and Negotiating to the Peer Review Committee. The Executive Committee authorized the Foundation Board of Directors to negotiate with Prudential Medicare and the Board of Health (Medicaid) to establish methods of peer review with those carriers, including the development of payment guidelines (Parameters). Negotiations with the Government Carriers would include the appointment of temporary consultants by the Foundation and the retention of the MAG Peer Review Committee as the State Appeal Board.

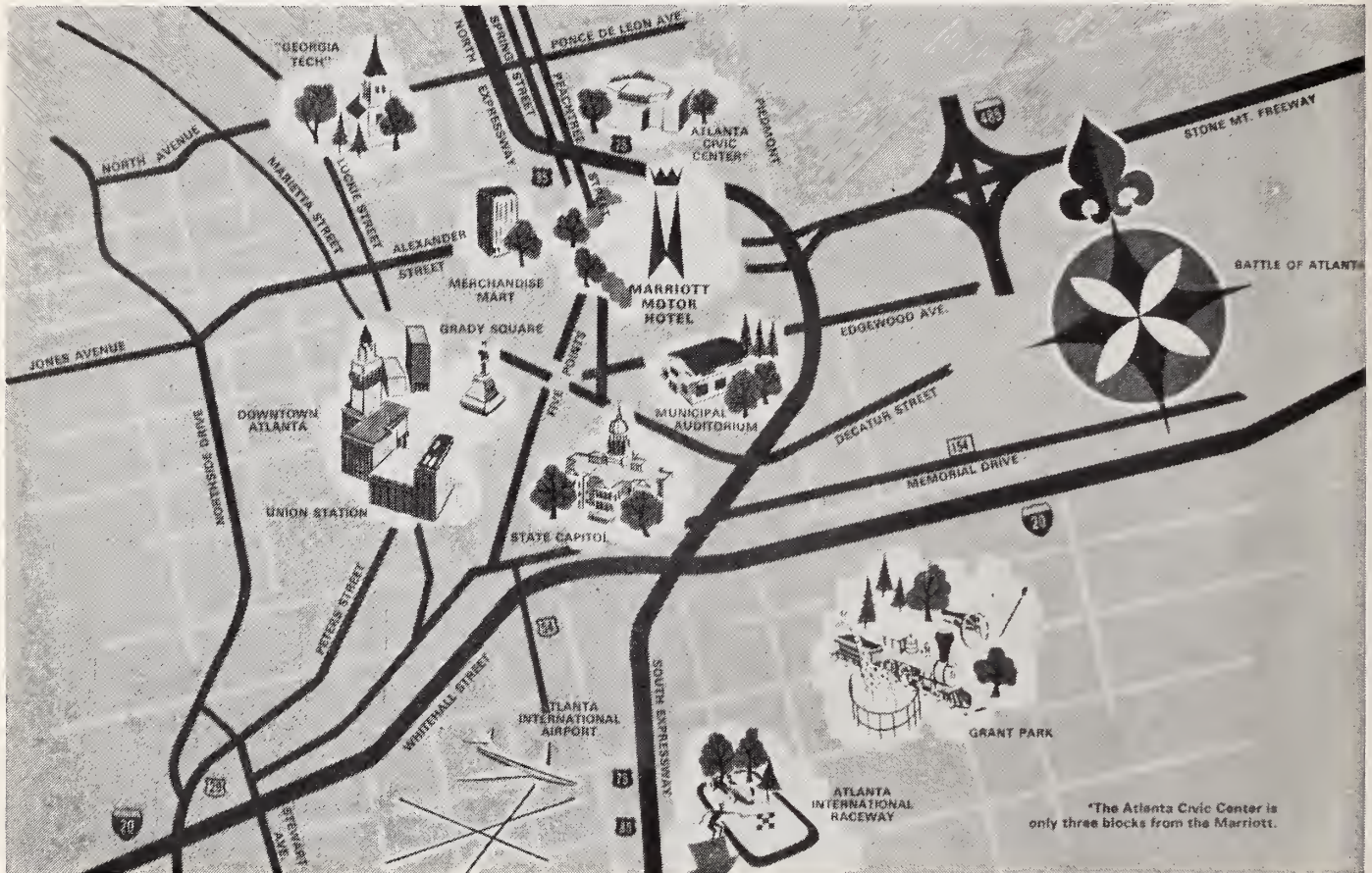
Licensure: Voted to urge the Composite State Board of Medical Examiners to rehear and reconsider the case of Sanford A. Shmerling, M.D.

Certificates of Appreciation: Compiled a list for recommendation to Council of those deserving recognition for outstanding contributions to MAG.

Shut-ins: Referred to the School Child Health Committee the question of when home-bound teachers should visit shut-in students.

Next Meeting: 9:00 a.m., Sunday, April 4, 1971, Conference Room, MAG Headquarters, Atlanta.

Come to Atlanta in May



THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 13, 1971

- 8:30 a.m.—Registration Opens
- 9:00 a.m.—Specialty Society Meetings (See March Program Issue)
- 2:00 p.m.—Auxiliary Pre-Convention Executive Board Meeting
- 6:30 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 14, 1971

- 9:00 a.m.—First General Session
First Session, House of Delegates
General Meeting
- 10:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—Health Care"

- 6:30 p.m.—Alumni Receptions and Dinners

Saturday, May 15, 1971

- 9:00 a.m.—Reference Committee Meetings
- 9:00 a.m.—Auxiliary General Meeting
- 2:00 p.m.—General Meeting—"America—The Drug Scene"
- 6:30 p.m.—Annual Reception and Banquet

Sunday, May 16, 1971

- 9:00 a.m.—Second General Session
Second Session, House of Delegates
- 9:00 a.m.—Auxiliary Post-Convention Executive Board Meeting
- 12:00 noon—Adjournment

Medical Association of Georgia Annual Session

May 13-16, 1971—Atlanta, Georgia
RESERVATION REQUEST

1. Please complete this form and mail directly to: Reservation Department
Marriott Motor Hotel
Courtland and Cain Sts.
Atlanta, Georgia 30303
2. Special reservation cards will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
3. Assignment of rooms will be made in the order of receipt of reservation. If possible, confirmation will be in accordance with preference indicated; if not, best substitute will be made.
4. Unreserved accommodations will be released on May 1, 1971.
5. Rooms will not be ready for occupancy until 2:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.
6. A quick check out card will be placed in each room. Turn this in at Registration Desk and you will be billed later.

DAILY MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Bedroom	Suites	Each Additional Person
1 person \$22-26	\$35-100	under 12 no charge
2 persons \$28-32		each additional person over two \$3.00
		roll-away in room \$4.00

ALL RATES PLUS 3% GEORGIA STATE SALES TAX

Cut out and send to the Marriott:

Please type or print

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION
MAY 13-16, 1971

NAME

ADDRESS

CITY & STATE ZIP

ARRIVAL DATE DEPARTURE DATE

TYPE ACCOMMODATIONS DESIRED FOR # OF PERSONS



THEY ALSO SERVE

CIRCUMSTANCES PREVENT MANY from being "where the action is," but this does not preclude service in kind for those who "mind the store" while a colleague, partner, or other associate contributes to "the action."

Many of our physician members who serve in support of the functions and services of the Medical Association of Georgia do so at their own expense of time, money, and leisure, thereby losing financially by absence from their practices and losing leisure hours also; many of our meetings of committees and boards are scheduled for weekends.

In the majority of instances these dedicated members who compose the membership on our councils and committees have partners or colleagues who spend extra time to see that the patients of the absent members are properly cared for, thereby negating such absences. However, there are far too many who do not enjoy this relationship; if there is one single member of the Medical Association who serves *but does not have a "backup man," this is one too many.*

Then there are among our membership individuals who criticize unjustly but who vehemently refuse to serve in any capacity to offer aid. In this day and age we, as physicians, are maligned and set upon by forces who would take over health care but who are not qualified to do so. We need the help of every physician in our organization to unhesitatingly prove to the public, and ourselves, that we do not have anything to hide and if there are those amongst us that are not true to the ideals of our profession, let us apply censure and correction—we can and we should!

Many of our colleagues are energetic and dedicated and prefer to provide leadership in many civic, educational, religious and political arenas and this is good and as it should be. These services are important not only to the organizations themselves but to each of us as citizens in the community. These services have been recognized by the institution of a Civic Service Award which is presented at the annual meeting of the Medical Association of Georgia, if such an individual is so designated by his local society. Several of our members have persevered and are providing leadership in many areas, in spite of personal and public attack.

At this point, may I state that whatever I may have contributed has not been at any sacrifice on my part or cost to me (other than some out of pocket expenses and maybe a little time away from home) because of the leniency of my partners. Drs. R. B. Quattlebaum and Dewey L. Barton, whose only stipulation regarding my many absences has been that I mark the calendar with scheduled meetings. They have worked out their own system of automatic coverage provided during my absences. For this I am very grateful and eternally appreciative.

If the substance of this letter sounds like "meddling" or "preaching," there are probably elements of each, depending on the reader.

Please remember, "they also serve who stand and wait" and paraphrased—"they also serve who stay and work."

A handwritten signature in dark ink, reading "F. G. Eldridge". The signature is fluid and cursive, with a long, sweeping underline.

F. G. Eldridge, M.D.

President, Medical Association of Georgia



TREATMENT OF SADDLE EMBOLISM OF THE AORTIC BIFURCATION

MILTON F. BRYANT, M.D., *Atlanta*

AN EMBOLISM MAY BE DEFINED as the sudden, partial or complete occlusion of an artery by lodgement of a clot or foreign material arising in another part of the circulatory system. The actual rate of occurrence of embolic episodes in the general population is unknown. Certainly embolic occlusion of the aortic bifurcation is not rare and all physicians must be prepared to recognize and treat this vascular catastrophe promptly.

The etiology of emboli at any site varies. Most emboli originate in the heart and auricular fibrillation is usually present. Mitral valvular disease may be obvious. Myocardial infarction or cardiomyopathy with secondary mural thrombosis may lead to an embolic episode. Embolism may follow mitral or aortic commissurotomy. An aortic atherosclerotic plaque will occasionally become dislodged and occlude the aortic bifurcation. Embolism secondary to unusual aortic and cardiac lesions, e.g. atrial myxoma, may occur and provide the first clue to the underlying disorder. Rarely, paradoxical embolism may occur through an opening between the right and left sides of the heart. Showers of emboli or a single embolus may occur and once the event is recognized one must be alert for subsequent episodes. The emboli usually lodge at the site of bifurcation of an artery or at points of narrowing. Large emboli commonly lodge at the bifurcation of the common femoral artery and only one out of eight embolic episodes occurs in the upper extremities. In many cases blood distal to the embolus will clot and form a comet-like tail.

The alliterative four P's of arterial embolism diagnosis are helpful: Pain, Paleness, Paresthesia, and Pulselessness. Pain in acute arterial closure is frequently severe. Paresis may occur distal to the embolism and reflexes are frequently absent. Most embolic episodes in large arteries cause complete obstruction; however, partial occlusion occasionally occurs with the presence of weak pulsations distal to the site of embolism.

In general, the treatment is immediate surgical removal of the embolus. Immediate heparinization is indicated to prevent clot formation in the arterial tree distal to the embolus. Current experimental studies of the potent thrombolytic agents—urokinase and streptokinase—may result in future modification of this therapeutic approach. Conservative management may be considered if adequate collateral circulation is present or if the patient's condition is obviously moribund. Presently most surgeons agree that aortic bifurcation emboli should be removed under local anesthesia. Both common femoral arteries are exposed and Fogarty catheters are passed in a retrograde manner proximal to the embolus. The balloon is then inflated and the embolus is extracted. The arterial tree must be completely cleared, both proximally and distally, with the Fogarty catheter in order to re-establish normal blood flow. Occasionally one cannot dislodge or fragment the embolus and the aortic bifurcation must be approached directly by either the transperitoneal or retroperitoneal route. Following successful embolectomy the source of embolic material should be identified where possible, and a decision made regarding efforts to prevent further embolic episodes.

1938 Peachtree Rd., N.W. 30309

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



LAWYER PAYS FOR PHYSICIAN'S MALPRACTICE

JOHN L. MOORE, JR., *Atlanta**

A 1970 DECISION of the Supreme Court of Minnesota required an attorney to pay more than \$100,000 damages to his client for failure to file suit against the client's psychiatrist for his malpractice within the two years allowed by Minnesota law. The facts of the case and the holding of the court present an extremely interesting case for analysis in this modern day of malpractice actions against professional persons.

Facts of the Case

Mr. Christy had had considerable trouble with alcohol and drug addiction. He underwent surgery for repair of a hernia in 1961. A week later, after an uneventful physical recovery, Mr. Christy consulted a psychiatrist because of a state of mental depression following the operation. The psychiatrist hospitalized Mr. Christy with "acute anxiety reaction." There followed three months of periodic hospitalization and discharge. During that period of time Mr. Christy changed to another psychiatrist, Dr. Cranston.

Dr. Cranston once again hospitalized Mr. Christy. Mr. Christy underwent seven electroshock treatments at two day intervals. On the morning of July 10, 1961, Mr. Christy received his seventh electroshock treatment. During the day the hospital contacted Dr. Cranston because it appeared that Mr. Christy's hospitalization insurance was running out on July 10.

Without any personal reevaluation of the patient, Dr. Cranston ordered him discharged by the hospital over the telephone. Mrs. Christy took the patient home and telephoned Dr. Cranston to obtain prescriptions for drugs. Dr. Cranston prescribed paraldehyde in dosages of one teaspoonful at a time. The bottle obtained from the druggist contained 16 teaspoonfuls of paraldehyde. In addition, Dr. Cranston prescribed 15 tablets of 50 mg. of mellaril to be taken twice daily at 8:00 A.M. and 6:00 P.M.

Even though the hospital records showed that Mr. Christy apparently had become addicted to paraldehyde and constantly asked the nurses for more of it, Dr. Cranston did not give any particular cautioning to the patient or his wife.

Late in the night after Mr. Christy's discharge, he was discovered asleep in a chair which was ablaze, apparently set by Mr. Christy's smoking. Mr. Christy was a compulsive and inveterate chain smoker. The patient suffered second and third degree burns over 30 per cent of his body and required 10 surgical procedures thereafter.

Apparently, by November, 1961, Mr. Christy was well enough to consult Mr. Saliterman, an attorney. Mr. Saliterman accepted a retainer and apparently obtained Mr. Christy's authorizations for the attorney to examine medical and hospital records. Mr. Saliterman apparently obtained photostatic copies of records from the hospital and from time to time reassured Mr. and Mrs. Christy that the

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

matter was being taken care of. However, Mr. Saliterman allowed the two year statute of limitation to run on July 11, 1963, without having filed suit against Dr. Cranston. Mr. Christy obtained other counsel who sued Mr. Saliterman.

Jury Verdict

Mr. Christy, in order to recover from his attorney, had to prove first that a contract existed between him and Mr. Saliterman creating an attorney-client relationship. Further, Mr. Christy had to prove that Dr. Cranston had been guilty of malpractice and that, if the suit had been brought against Dr. Cranston, Mr. Christy would have prevailed. Finally, the jury had to determine the amount of damages to which Mr. Christy was entitled.

The jury found for Mr. Christy all the way. It held Mr. Saliterman liable to Mr. Christy for \$150,000 of general damages plus all of Mr. Christy's hospital and medical expenses after he was burned.

Decision of Supreme Court

The Supreme Court of Minnesota, in a careful review of the trial before a jury, found that there was an adequate basis for the jury's finding that the attorney-client relationship did exist. It also found that the jury had a reasonable basis for finding that Dr. Cranston had been negligent in discharging Mr. Christy on the same day he had had an electroshock treatment, especially since he did not warn Mr. and Mrs. Christy as to the dangers from overdoses of paraldehyde. However, in considering the amount of the verdict against the attorney, the Supreme Court found that it could not in good conscience hold the attorney liable for as much as \$150,000 of general damages. Mr. Christy apparently had not suffered permanent disability from his injury and was once again employed as a car salesman without loss of income except during the time of his hospitalization and treatment for the burns. Accordingly, the Supreme Court of Minnesota reduced the verdict from \$150,000 to \$100,000 to which was added \$3,530 of special damages. The Supreme Court rejected the attorney's argument that the verdict should be further reduced by the amount he would have received as attorney for Mr. Christy if he had sued Dr. Cranston in time and won a verdict of \$100,000.

Comment

The undersigned is frequently asked by physicians whether lawyers are ever sued for malpractice. It is intriguing to find a case where not only was the attorney sued but where he had to pay damages which apparently otherwise would have been paid by a physician.¹

*Suite 1220
C&S Bank Building*

1. The case discussed above is *Christy v. Saliterman*, 179 N.W.2d 288 (Sup. Ct. Minn. 1970).

PROGRAM AID

MAG has obtained a copy of a new film entitled "Narcotics: Pit of Despair." This film, running 28 minutes, is in beautiful color, and can be shown on any 16mm sound projector. It is designed for school and other public groups and can be reserved by contacting Mr. Carl Bailey, Field Representative, MAG.

THE ASSOCIATION



NEW MEMBERS

Alvarez-Mena, Sergio C. Central State Hospital
Active—Baldwin—I Milledgeville, Georgia 31062

Barnwell, William L. 1217 Memorial Dr.
Active—Whitfield—OPH Dalton, Georgia 30720

Bonner, John T. 69 Butler St., S.E.
Active—Fulton—Anes Atlanta, Georgia 30303

Branch, John L., Jr. 86 S. Cobb Dr.
Active—Cobb—Ind Marietta, Georgia 30060

Brewer, Philip L. Medical Arts Bldg.
Active—Muscookee—TS Columbus, Georgia 31901

Carter, Mary Jo Medical College of Georgia
Active—Richmond—I Augusta, Georgia 30902

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Active—Fulton—OBG Atlanta, Georgia 30303

Gilbert, Carl N. Memorial Dr.
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Active—Fulton—OBG East Point, Georgia 30344

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Active—Baldwin—P Milledgeville, Georgia 31062

Portillo, Lorenzo A. Del Central State Hospital
Active—Baldwin—P Milledgeville, Georgia 31062

Price, Sandy L. 6075 Roswell Rd., N.E.
Active—Fulton—D Atlanta, Georgia 30328

Pugh, James W. 461 King Arnold St.
Active—Fulton—GP Hapeville, Georgia 30354

Rockel, Thomas H. 69 Butler St., S.E.
Active—Fulton—N Atlanta, Georgia 30303

Ross, Gerald W. 780 E. Third St.
Active—Spalding—GP Jackson, Georgia 30233

Simmons, Robert W. 1714 Felton Rd.
Active—Whitfield—GP Dalton, Georgia 30720

Simonton, Kinsey M. 705 Juniper St., N.E.
Active—Fulton—OTO Atlanta, Georgia 30308

Teeslink, C. Rex 1467 Harper St.
Active—Richmond—R Augusta, Georgia 30902

Thompson, Richard E. P.O. Box 951
Active—Muscookee—PD Columbus, Georgia 31901

Threefoot, Sam A. VA Hospital
Active—Richmond—I Augusta, Georgia 30904

Touchton, Mary J. 107 Clinic Ave.
Active—Carroll-Douglas-Haralson Carrollton, Georgia 30117

Waiker, Moffett R., Jr. Box 3210
Active—DeKalb—I Atlanta, Georgia 30302

Ward, Daniel F. 1467 Harper St.
Active—Richmond—P Augusta, Georgia 30904

Wilhelm, John A. 275 Fifth St., N.E.
Associate—Fulton—GP Atlanta, Georgia 30308

Zilis, James J. 438 E. Broughton St.
Active—Decatur-Seminole—OBG Bainbridge, Georgia 31717

PERSONALS

First District

John Kirk Train has been named to the State Board of Health.

Second District

Carl S. Pittman, Sr., has retired from the Tift County Board of Health after 40 years of service.

Fifth District

Bruce Logue recently was visiting Professor of Medicine at the Medical College of South Carolina, Charleston, S.C. and the University of Puerto Rico, San Juan, P.R., as well as guest lecturer at the Orangeburg Re-

gional Hospital Seminar in Orangeburg, S.C. and at meetings of the American College of Physicians in Columbia, S.C.

E. Garland Herndon, Jr., has been appointed associate dean of the Emory University Medical School and medical director for Emory University Hospital.

Nicholas E. Davies has been named winner of the annual Aven Cup Award, given by Fulton County Medical Society for outstanding citizenship in Atlanta community affairs.

Donald Fellner conducted a seminar in February for some 35 coaches and sports officials in East Point on procedures for treating a variety of injuries.

Sixth District

F. Donald Bass was named a Fellow of the American College of Surgeons in February.

Eighth District

Lewis Chisholm was presented with the Silver Beaver award at the annual Alapaha Area Council Boy Scouts of America awards banquet in February. The Silver Beaver is the highest award given in Scouting.

Tenth District

Robert G. Ellison has been elected president of the Society of Thoracic Surgeons.

DEATHS

Roy L. Gibson

Roy L. Gibson died February 19 at the Medical Center in Columbus following a brief illness. He was 61.

A prominent Columbus physician and member of the Georgia State Board of Health representing the Third Congressional District, Dr. Gibson served as chairman of the Board of Health's mental health committee. He had long championed help for the mentally disturbed in Georgia and strongly backed a state program of regional mental hospitals including one scheduled for construction in Columbus.

Dr. Gibson was a native of Columbus and had been in private practice there since 1938. He was formerly chief of staff of the Columbus Medical Center, and was a past president of the Muscogee County Medical Society.

During World War II he achieved the rank of major, serving with the Emory University Medical Unit. He was graduated from Emory in 1931 with an A.B. degree, receiving his M.D. degree from the Medical College of Georgia in Augusta in 1935. Dr. Gibson later served as a trustee of the Medical College, and was also a trustee of Andrew College in Cuthbert, Ga.

In 1969 Dr. Gibson received the Sertoma Club's "Service to Mankind" award. He was a member of Trinity Episcopal Church, the Kiwanis Club of Columbus, the Southern and American Medical Associations, and the Medical Association of Georgia. He was a fellow of the American College of Surgeons, the International College of Surgeons and the American College of Obstetricians and Gynecologists.

He is survived by his widow, the former Mrs. Frances Lummus Mayher of Columbus, two sisters and his mother.

Robert Lewis Rhodes

Robert Lewis Rhodes, 85, the first Georgia surgeon to perform a Caesarian section, died February 16 in an Augusta hospital following a brief illness.

Born in Mathews, Ga., Dr. Rhodes received his B.S. degree from Emory University in 1906 and his M.D. degree from Johns Hopkins Medical School in 1910.

One of the first surgeons in the world to perform open heart surgery, he was instrumental in pioneering many of today's modern surgical techniques.

Dr. Rhodes was a member of the Richmond County Medical Society, the First Southern Methodist Church, and was a past faculty member of the Medical College of Georgia.

Dr. Rhodes is survived by his son, Robert Lewis Rhodes, Jr., of Augusta; two sisters, Mrs. Frank Hardeman of Louisville, Ga. and Mrs. Robert Parham of Jacksonville, Fla., a grandson and two granddaughters.

Harry A. Wasden

Harry A. Wasden died February 17 at Archbold Memorial Hospital in Thomasville at the age of 64.

Dr. Wasden was serving his second term as a Quitman city commissioner. He was also a member of the American Society of Abdominal Surgeons, the Medical Association of Georgia, American Medical Association, Southern Medical Association, the American Association of Railway Surgeons, board of directors of the Arthritis Foundation of Georgia, Medical College of Georgia Foundation and the Board of Surgeons for both Seaboard Coast Line and Southern railroads.

He was also a member of the Georgia Municipal Association, was a Shriner, an honorary citizen of Boys' Town, Neb., and a member of the board of directors of the Georgia YMCA.

Dr. Wasden is survived by his widow, the former Sarah Riley; a daughter, Mrs. LeFils Mannos of Atlanta; a son, Bill Wasden of Honolulu, Hawaii, and a brother, William T. Wasden of Millen.

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THE MONTH IN WASHINGTON

The American Medical Association's 1971 Medigap national health insurance program was introduced in both chambers of the Congress with more than 100 Democratic and Republican sponsors.

The three chief sponsors again were Sen. Clifford Hansen (R-Wyo.) and Reps. Joel T. Broyhill (R-Va.) and Richard Fulton (D-Tenn.). They and Dr. Russell B. Roth, speaker of the AMA House of Delegates, held a joint news conference on capitol hill in connection with introduction of the legislation (H.R. 4960 and S. 987).

There are two major differences between this Medigap legislation and the bill introduced last year. Catastrophic coverage has been added, and the peer review provision dropped because Congress is expected to approve such a program before considering national health insurance.

Medigap would:

1. pay the full cost of health insurance for those too poor to buy their own,
2. help those who can afford to pay a part of their health insurance premium. The less they can afford to pay, the more the government would help out,
3. see to it that no American would have to bankrupt himself because of a long-lasting, catastrophic illness.

Government Pays

The government would pay all of the premium for low-income beneficiaries—an individual and his dependents without any income tax liability. For others, the government would provide scaled participation ranging between 97.5 per cent and 10 per cent, favoring lower-income persons, in the payment of premiums for catastrophic expense coverage, but there would be a "financial corridor" based on income before such coverage would begin.

A beneficiary eligible for full payment of premium by the federal government would be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Eligible beneficiaries with whom the government would be sharing the cost of premium could elect between a credit against income tax or a certificate.

To participate in the Medigap program, a carrier would have to qualify under state law, provide certain basic coverage, make coverage available without pre-existing health conditions, and guarantee annual renewal.

Policy Offerings

A qualified policy would offer comprehensive insurance against the ordinary and catastrophic expenses of illness. Basic benefits in a 12-month policy period would include 60 days of inpatient care in a hospital or 120 days in an extended care facility. Other basic benefits would provide emergency and outpatient services and all medical services provided by doctors of medicine or osteopathy. The catastrophic expense protection would pay incurred expenses for benefits in excess of the basic coverage, including hospital, extended care facility, inpatient drugs, blood, prosthetic appliances, and other specified services.

Under the basic coverage, there would be a deductible of \$50 per hospital stay, and 20 per cent co-insurance of the first \$500 of medical expense and on the first \$500 of emergency or outpatient expenses. Under the catastrophic illness provisions, the amount of the "financial corridor" would be based on taxable income: 10 per cent on the first \$4,000, 15 per cent on the next \$3,000, and 20 per cent thereafter.

A health insurance advisory board of 11 members, a majority of whom shall be practicing physicians, and including the secretary of Health, Education and Welfare and the commissioner of internal revenue, would be appointed by the president with Senate consent. The board would establish minimum qualifications for carriers, and in consultation with carriers, providers and consumers, would develop programs designed to maintain the quality of health care and the effective utilization of available financial resources, health manpower, and facilities.

Medigap Benefits

At the news conference, Dr. Roth said:

"Medigap offers four important benefits.

"It protects families and individuals from the financial catastrophe that can result from illnesses requiring protracted care.

"It enables people to receive *federal assistance* for health and medical care.

"It offers an individual or a head of a family, no matter what his income, the opportunity to select from among *private* medical plans the one best suited to his needs. If he does not like one plan, he can try another. In effect, Medigap says to everyone, 'Here's some federal assistance. Take it and use it for the sort of health care you want.'

"And Medigap provides these benefits at a cost estimated at \$14.5 billion for the first year—considerably lower than nearly all other national health proposals. In other words, Medigap will have a relatively modest impact on the tax increases necessary to finance any national health plan; it will thereby contribute less to the inflationary pressures which plague us all."

Congressional View

The three congressmen each keyed in on one of Medigap's three main provisions.

"The current federal-state health program for the poor (Medicaid) has been sick for a long time," Fulton said. "Some states offer good and adequate medical benefits, others offer substandard medical care and at least two states do not even participate in the program for their citizen poor. . . .

"The time has arrived to standardize the benefits in every state of the union guaranteeing to the poor of every state an adequate level of health care. The voucher system for the poor clearly states that the Federal Government will totally finance the cost of a basic, stated set of minimum benefits to the citizens of every state in the union."

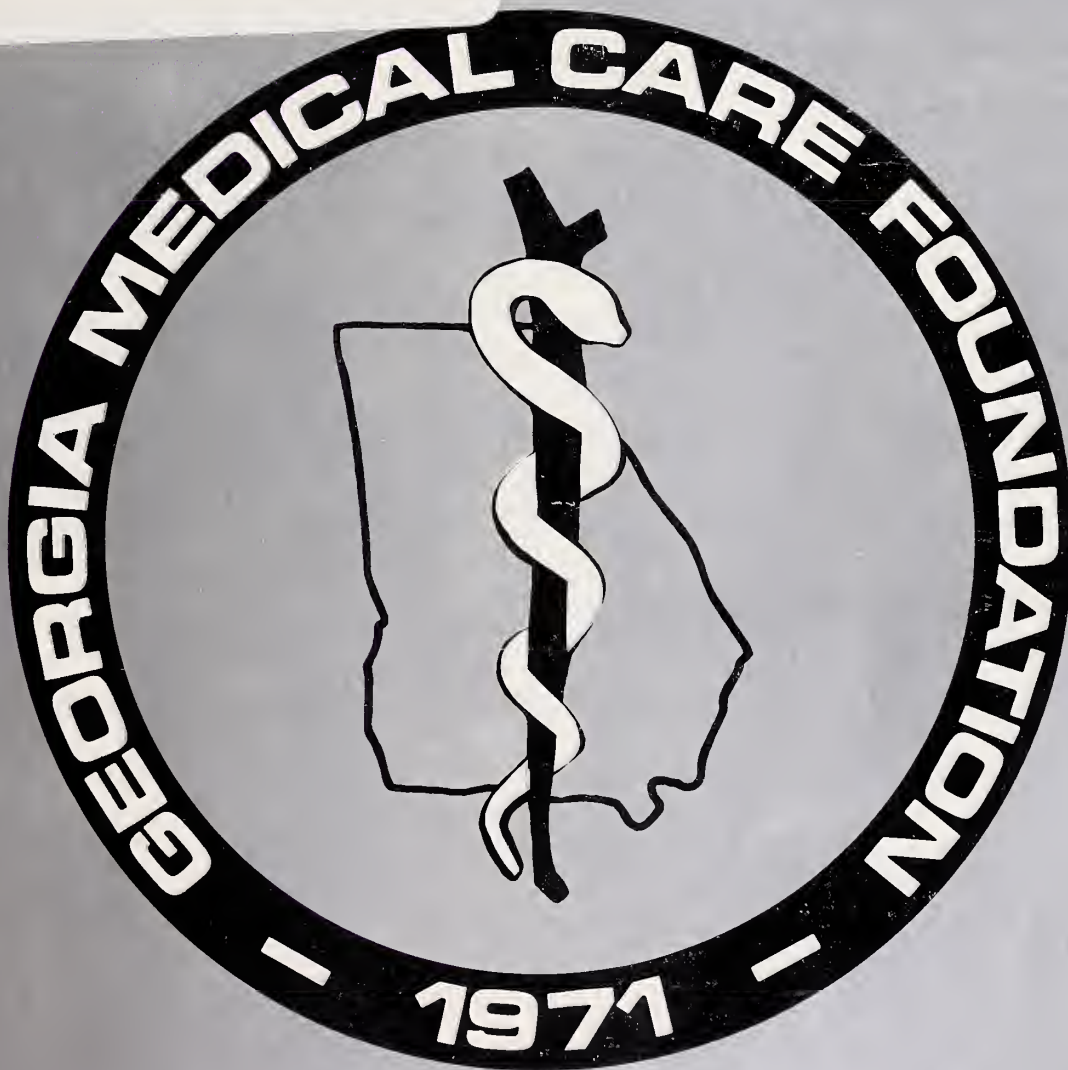
"The tax credit feature of Medigap is designed primarily to help low income families above the poverty level buy basic coverage health insurance," Broyhill said.

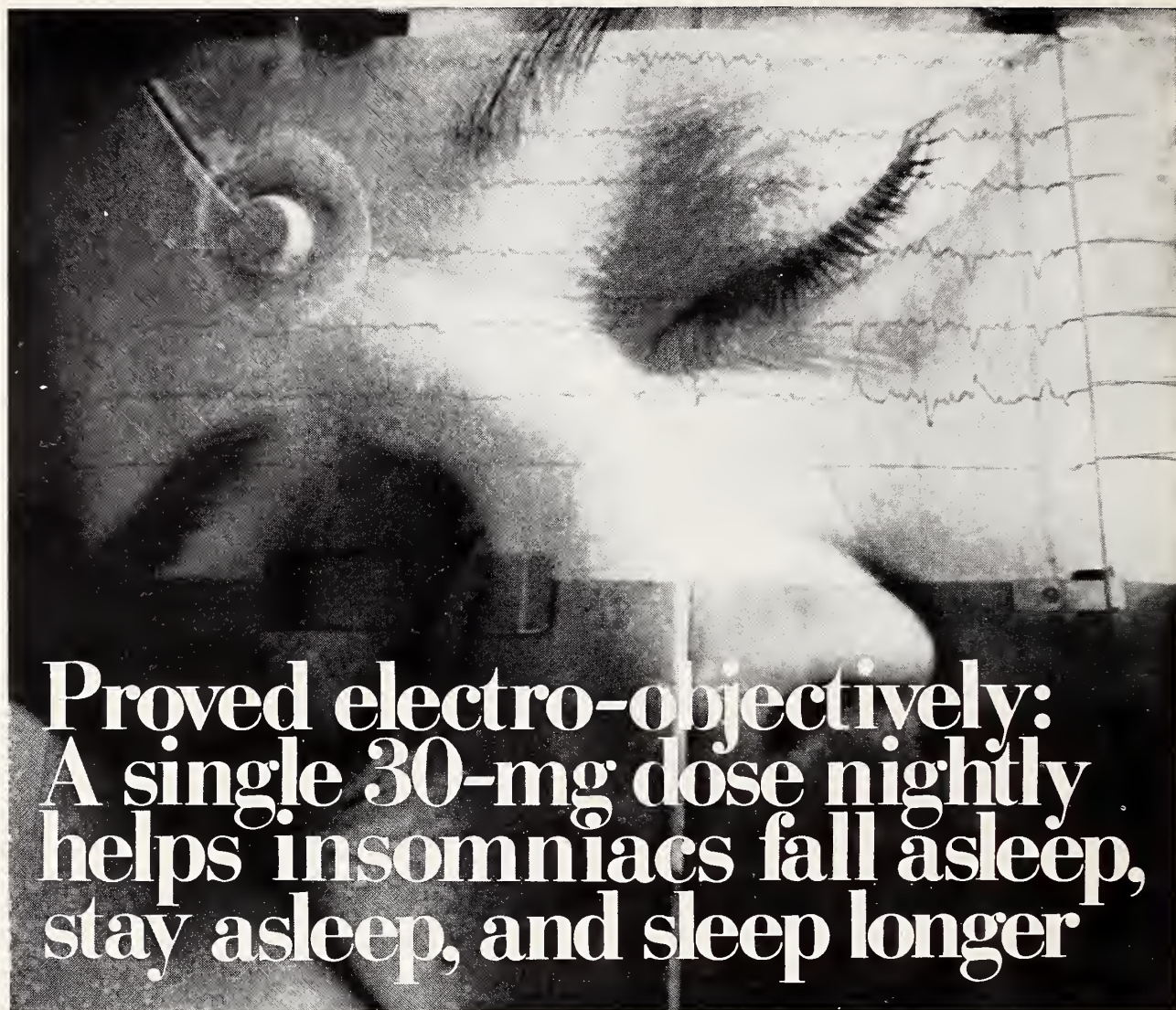
JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,⁴ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

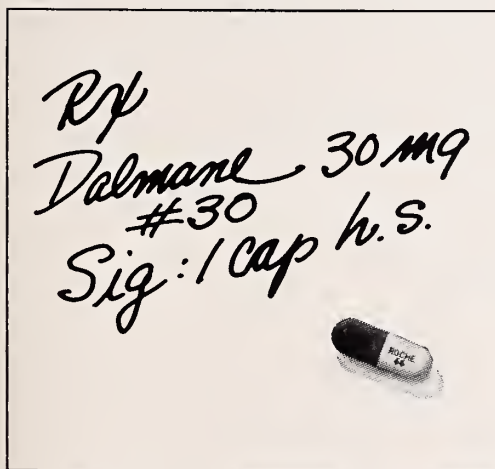
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane**[®]
(flurazepam hydrochloride)

Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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Official seal of the Georgia Medical Foundation, Inc. Design by Charles Wood, Atlanta.

Georgia Medical Care Foundation

F. W. DOWDA, M.D., *Atlanta*

ONE OF THE RARER OPPORTUNITIES that is presented to an individual during his lifetime is the opportunity to work for a good cause with fine people. I think this is the way your Executive Committee and your Council of the Medical Association of Georgia feel about the fine work which has gone into the Georgia Medical Care Foundation.

The Medical Care Foundation in brief is an exercise in enlightened self interest. In order to understand how it works, it will be necessary for you to know some of the informational background that led to the development of the first foundation.

Many years ago in a small town in California, the medical society found itself in competition with a closed panel practice group for a large labor contract. The loss of this labor group to the practicing physicians in the community would have been an economic disaster and they set about trying to devise a plan which indeed would permit them to enter into competition with this group. Very quickly they found themselves in conflict with certain antitrust laws and restraint of trade laws, and found it necessary to develop a subsidiary corporation to their medical society specifically designed to handle the problem which they wanted to handle and that basically was the establishment of minimum insurance standards and subsequent claims review. So successful were they in this particular endeavor that not only did they win the contract that they were seeking but they have had a contract renewed steadily every year for the last 15 years, and it seems to be a happy symbiotic working relationship between the labor people and the community of Stockton, California and the doctors in practice in that area.

The term foundation grew out of this encounter in trying to establish the original proposal in that the organization with which they were competing was already called a foundation and in order to make bidding on a truly competitive and easily vot-

able basis, it was deemed desirable at that time that the original subsidiary corporation of the medical society would indeed itself be called a foundation. The name has stuck and although the people have complained from time to time that it is cumbersome, it is probably here to stay.

Let's go back now for a moment and examine a couple of the ingredients that enter into this particular problem. Number One is the situation of the patient in-put into the problem. Several years ago, Dr. Dwight Wilbur in his inaugural address on assuming the presidency of AMA pointed out that we indeed did live in a republic and we will be permitted through this republican process to practice medicine in the fashion that we desire to practice it only in so far as the public deems that we are doing a good job and will permit us to do so. The foundation takes Dr. Wilbur's statement very literally as indeed I feel it should and seeks: to insure that the public gets a fair shake for its insurance dollar; no small print; no hard to understand provisions—just clean cut insurance policies with excellent coverage; therefore, it is appropriate that one of the first actions that the Board of Directors of the Georgia Medical Care Foundation undertook was the establishment of Minimum Standards for Insurance Policies in the State of Georgia and we feel that these will undoubtedly stick. However, let's look at this particular problem a little more carefully. When one is establishing minimum standards for insurance policies, we are spending somebody else's money. Not only do we have an obligation to the patient but we also have an obligation to the third party payor who is making health care possible through financial means for this patient. This responsibility to this third party payor is to insure that his money is properly utilized and soundly spent and this indeed is one of the big tasks that the foundation will attend itself to.

The following is a flow sheet of how claims will

GEORGIA FOUNDATION / Dowda

be handled by your Georgia Medical Care Foundation including the appeals process, for under every adjudication process, there must be an appeals process.

- I. Carrier submission of claims to foundation**
- II. Foundation administrative processing of claims**
- III. Review of claims by:**
 - A) Foundation consultant**
 - B) Foundation specialty panel**
 - C) Foundation Board of Directors**
- IV. Appeal procedure through**
 - A) Local or District Medical Society Peer Review Committee**
 - B) MAG State Peer Review Committee**
 - C) MAG Executive Committee**

Now what have been the results and what is the experience with this particular claims review process up until now? In essence, it has shown physicians probably to be, as we have always suspected, the most honest of people available. Eighty-five per cent of the claims passed through the foundation without any question of any kind because they fall within the guidelines as O.K.'d by your foundation. Fifteen per cent of physicians' claims do come under review. Fourteen per cent of these are found to be justified (this is still referring to the basic initial 100 per cent) and only 1 per cent of the total of physicians' claims are in any way altered by your foundation. I think these statistics indeed do show that one of the best bargains that the American public still gets for its dollar is the health care dollar spent in the physician's office. Also, I feel statistically for the most part, that this process of claims review indicates that probably most physicians do not charge adequate office fees to cover their services; however, health care costs do tend to soar and it is our responsibility and our job to try to do something to contain the increases which are inevitably going to occur every year.

How can we do this? A real critical analysis of the problem indicates that the majority of the health care dollar is being spent for Nursing Homes and for hospitals and that a minority of the health care dollar is being spent in the physician's office and in the neighborhood drug store. Further analysis indicates that the most effective type of health care is preventive care and early treatment care in the physician's office and once the patient becomes ill enough to enter the hospital, that morbidity, mortality and costs all climb rapidly. I think one of the

big tasks that your foundation is going to have is the re-location of health care delivery from the hospital back into the doctor's office. For many years insurance policies of all kinds have paid for work that was done in the hospital and have steadfastly refused to pay for it in the physician's office. Your medical profession has for, I know 25 years, consistently and steadily pointed out the error and the fallacy in this thinking. One of the arguments used by insurance companies against the development of adequate policies in the office was the lack of ability to control utilization and that this particular argument has been taken away from them by the development of the foundation.

Up until now, we have been talking about what the foundation can do for the patient in the way of insuring them adequate insurance policies and what the foundation can do if there is a third party payor supplying the health dollar such as a company, a corporation, a businessman or the federal government, to insure adequate utilization of the health care dollar put into the system by this individual.

I think I would like to spend the last closing minutes with you in pointing out the advantages of the Georgia Medical Care Foundation and similar foundations around the country to the physician and I think in essence, we can say it consists of several parts. Number One is through the establishment of better insurance policies and a good review mechanism in your foundation. Not only can payments of more adequate amount be made to the physician, but they are made more promptly, and the latter can be just as important as the former. If one would consider the loss of time and investment opportunities with the money that are dependent upon delays in reimbursement processes such as you have encountered under the federal programs in this state over the last several years, this alone is almost adequate incentive for joining the foundation. For non-foundation members, reimbursement will be made to the patient and not the physician directly; however, I think there is an even more important reason for your being a member of the Georgia Medical Care Foundation.

Medicine is at the cross-roads right now of becoming a nationally socialized and nationally run and controlled profession out of Washington. I don't believe this is going to happen for the next couple of years. I think in this interval that if medicine can unite into an effective bargaining tool to show that it is able to produce good quality of performance with accessibility and acceptability built into the system and cost containment built into the system through the transformation of medical practice from a hospital based to a physician office based system that

this socialization of our great profession will not occur. Foundations may not be the answer to everything and I am sure that people are going to continue to come up with alternative systems and approaches and answers to the problems that beset organized medicine at this time; however, I do feel that the Georgia Medical Care Foundation and similar foundations to it have appeared at a critical time in history. I believe that if medical societies around the country will embrace the system of foundations and operate them well as subsidiary corporations of the medical society subservient to the will of organized medicine that the goals that we hold dear can be achieved and the values which we hold important can be maintained.

I would urge your full cooperation and activity in the Georgia Medical Care Foundation as I urge your full activity and cooperation in the activities of the Medical Association of Georgia. We have an opportunity here for medicine to interface across the bargaining table with consumer and money supplier and to hold the trump cards because of excellence of performance but it can be done only if we all

work together and stick together during these very critical and trying times.

The following are a list of your directors of the Georgia Medical Care Foundation. They are elected by the Medical Association of Georgia Council. There are district representations plus the President, President-Elect and the Secretary of the Medical Association of Georgia are ex-officio members with a vote. In addition to this, specialty panels will be chosen from each district. These will be nominated by the district committee approved by the specialty society which they represent.

BOARD OF DIRECTORS

President and Treasurer:

F. W. Dowda, M.D., *Atlanta*

Vice President:

F. G. Eldridge, M.D., *Valdosta*

Secretary:

John Kirk Train, Jr., M.D., *Savannah*

Executive Director:

Edwin F. Smith (MAG, tentative)

490 Peachtree St., N.E., 30308

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL APRIL 4, 1971

FINANCE: Approved costs of County Society cassette cartridges (\$100 per month) to come from the discretionary fund. Authorized without limitation payment of expenses of Georgia Medical Care Foundation, Inc., on a loan basis, with staff time, supplies, direct and indirect costs applied for future reimbursement by the Foundation; a monthly Foundation Financial Report to be received by Executive Committee.

COMMITTEES: Appointed Chairmen and members of MAG Committees for 1971-72 and approved the combination of several Committees and their responsibilities, to be presented at the May meeting. Instructed the Executive Director to present a report in May on outside committees and liaison responsibilities for which Executive Committee makes appointments.

HEADQUARTERS BUILDING: Directed the Executive Director to report in May on the feasibility of further building expansion.

PUBLIC RELATIONS: Requested a report in May on the progress of Fulton County Medical Society's project in public relations.

GaMPAC: Requested a report in May on the structure and bylaws of GaMPAC, including the appointment of the GaMPAC Board and GaMPAC Executive Committee.

PEER REVIEW: Adopted a flow chart for the handling of claims review under the Georgia Medical Care Foundation and an organizational chart of peer review responsibility recommended by the Fulton County Medical Society.

FOUNDATION: Received for information a report from the Georgia Medical Care Foundation Chair-

man, F. W. Dowda, M.D., that he plans to meet with the Committee on Medical Care Administration of the State Board of Health on a peer review mechanism for Foundation processing of Medicaid claims.

REVIEW APPEAL: Heard an appeal of actions taken by the Peer Review Committee and determined that Executive Committee involvement would be for the purpose of determining if the Peer Review Committee had abused its discretionary privileges. Further consideration will be given to this appeal at the May meeting with the Chairman of the local Committee involved asked to attend.

COMMUNICATIONS WITH COUNTY SOCIETIES: Authorized the distribution of communication tapes to all County Medical Societies, regardless of their meeting schedule. Determined that the April message should include information on the 1971 Annual Session.

MULTI-PHASIC SCREENING: Referred to the Fulton County Medical Society information received on the establishment of a multi-phasic screening corporation in Atlanta.

STAFF: Authorized a staff re-assignment of parking, placing all female employees on "A" Deck.

APPOINTMENTS: Heard a report that Governor Carter had appointed Dr. Jim Sullivan, of Columbus, to the State Board of Health, representing the Third District.

NEXT MEETING: Noted its next meeting to be held at 9:00 a.m., Wednesday, May 12, 1971, in the Tara I Suite, Atlanta Marriott.

A Comprehensive Explanation of Foundations for Medical Care

MR. BOYD THOMPSON,* *Stockton, California*

THE FOUNDATION FOR MEDICAL CARE is a management system for community health services.

Traditionally it has been formed by medical societies as a separate corporation which is empowered to contract with physician-members of the medical society. The contract is an explicit agreement between the Foundation and the physician. It has all the force of an employment contract.

The objective of Foundations for Medical Care is to assure maintenance of high quality care for the community; to assume responsibility for gaps in access to care, and to assure the maintenance in the community of high standards of health insurance benefit levels.

In short, Foundations have been highly instrumental in assuring highly flexible insurance programs in their respective operative communities.

This means that in the western areas where most mature Foundations are operating there would be some question about the clamor for national health insurance. The insured public in these areas has wisely insisted on, for example, benefits for ambulatory care including adequate x-ray and laboratory benefits, coverage from birth, all consultations, and other components of health insurance which are not commonplace in the context of much of the voluntary health insurance as it is known in other large populous areas.

If health insurance is largely hospital-oriented, as critics are asserting, this does not hold true in those places where Foundations have been influential. These Foundations are the administrators of the public's health insurance expenditures.

Definition

A Foundation for Medical Care is an organization of doctors of medicine, sponsored by a local county medical society or a state medical association. It is a separate and autonomous corporation with its own board of directors. Every physician-member of the medical society may apply for membership in the Foundation and upon being accepted may partici-

pate in all programs and activities. Membership on the part of a physician carries with it the responsibility to accept all foundation contract obligations.

A Foundation is concerned with the development and delivery of medical services and the reasonable cost of health care, whether privately or publicly financed. A Foundation also believes in the American tradition of free choice of personal physician and hospital by the patient, the fee-for-service concept, and the local control of over and under-utilization through "peer review."

A Foundation establishes minimum standards for health care as practiced in the community which offer broad coverage within a reasonable cost level. The Foundation accepts the service principle of insurance, thereby making certainty of coverage available to all consumer groups covered by a sponsored program.

Quality of medical care is emphasized through utilization review techniques, both over-utilization and under-utilization, by both physician and the patient.

Functions

A Foundation, recognizing that health is a community affair, functions in concert with all segments of the community in upgrading existing health care programs and in experimentation and development of new health care programs. The latter involvement has specific interest in bringing medical care to those segments of the population that do not now have easy access to adequate medical care.

While it is true that Foundations for Medical Care found their genesis in the expansion of Kaiser-type programs, it must be recognized that Foundations are mushrooming these days not solely because of the expected proliferation of prepaid group practice plans. It is more correct to ascribe the thrust of the Foundation movement to the growing awareness that the medical establishment, which is responsible for 85 per cent of all health services, should in fact organize itself more appropriately to assume a major role in the management of these services.

* Executive Director, San Joaquin Foundation for Medical Care.

If there is any surprise reaction to such a dawning realization, it should not be forthcoming from medical care administrators and the many other experts in the provider sector, who for years have sought to convince the physician that he should assume the role of management in health affairs in addition to his role as manager of patient care.

"Non-System" Myth

There has been confusion about what a Foundation is and what it does for the health industry. So much has been said about the problems of the health system that it has come to be called a "non-system." Walter McNerney, of National Blue Cross, told the American Public Health Association this past year in Houston, Texas, about the myths that have come into being in connection with the crisis in health care organization and delivery. Among the myths he touched upon was the reference to the "non-system."

"If you don't think there is a health system, just try to change it," he commented.

But change is taking place and the Foundation for Medical Care is that organism of the medical establishment, the fee-for-service side of the aisle, which is responsive to the need for change.

Incentive

The physician who participates in a Foundation for Medical Care has as much incentive to control hospital utilization as does the salaried M.D. who participates in a prepaid group practice plan. He has just as much interest in maintenance of quality standards of care as does his peer who works within the group practice framework.

In operating Foundation areas the substantive insurance benefits for ambulatory care provide the same incentive for outpatient treatment as would occur in a prepaid group practice program such as Kaiser. This is accomplished in true community fashion by the Foundation's sponsored insurance company programs and programs underwritten by the Blues, if these programs meet Foundation standards.

Foundations also participate directly with self-insured groups and the Federal Employees Health Insurance Program subcontracting for a portion of the risk.

Quality Care

The second concept, the quality of care aspect, relates to the commonly heard proposition that a physician who is employed in a group practice works among his peers and is subject to close scrutiny of

his work. Hence the conclusion is that the group practice situation insures top quality medical care.

Foundations for Medical Care make the same claim. In short, all cases which are processed through the Foundation mechanism are scrutinized primarily from the standpoint of quality of care. Patient and provider profiles are accumulated and analyses are regularly run from the standpoint of the particular case. They are also run to discern trends in quality and utilization of services.

Prepaid Care

Foundations are continuing to experiment with the prepayment of health services. This is where Foundations for Medical Care move into the area of health maintenance organizations, for implicit in the HMO concept is prepayment, which is paying ahead of time for all health services.

While there have been several consumer health programs which have been administered on a prepayment basis by Foundations, the best known is Medicaid. For the past two years Foundations have been successful in working with the State on a capitation basis for Medicaid recipients and contracts have been negotiated whereby Foundation-participating physicians agree to a fixed rate of return for the total care rendered a total population segment over a stipulated period.

It means the doctors are risk sharing for Medicaid recipients. In the four-county San Joaquin program it was possible in 1969 to refund some \$200,000 to the State of California. In the past year the forecasting was off and proration of Medicaid funds was distributed to participating M.D.'s.

Welfare recipients in the counties of Sonoma, Mendocino and Lake are covered under a prepayment program of the Sonoma Foundation for Medical Care. This contract functions in partnership with an insurance company, thus providing the program with all of the needed financial, actuarial and managerial expertise possessed by the insurance industry.

Both the Sonoma and San Joaquin contracts show the difference between pre-payment in the FMC and in the Prepaid Group Practice. In the former the physician continues to receive his regular usual and customary fee within the broad framework of the overall capitation agreement. In most prepaid group practices, the physician is reimbursed on a salary basis.

Diverse Involvement

The diversity of involvement can be highlighted by a few examples: The Monterey Foundation for Medical Care provides medical services to migrants in its King City Project; the San Joaquin Foundation

EXPLANATION / Thompson

maintains two fixed and five mobile clinics for migrants providing over 8,000 visits per year, and is funded by the United States Public Health Service, San Joaquin County Board of Supervisors and the Regional Migrant Education Program. Regional Medical Programs fund a program in San Joaquin County of multiphasic screening and follow up care for 3,000 urban poor, in cooperation with the Consumer Health Council.

Other programs include community-wide utilization programs for extended care facilities; a new concept in certifying hospital admissions developed by the Sacramento Foundation; a coordinated medical utilization program that not only certifies hospital admissions but monitors the length of stay, proper placement of patients after leaving the acute facility and follow-through at each level of care; a pilot program under Medicare for Kern, Fresno and San Joaquin Foundations designed to develop patient profile information; and a contract with Pacific Mutual Life Insurance, Pacific National Life Assurance, California-Western States Life, and Occidental Life Insurance whereby the Foundations accept the responsibility of developing criteria of care to be utilized in a computerized prospective and retrospective review process.

Historically, Foundations have found their most successful tool for spreading better care throughout the community and at the same time giving certainty of care and quality control has been by setting minimum standards. This means sponsoring insured and service programs that meet these minimum standards. It also means becoming involved in the administration of these programs to the extent necessary to guarantee quality.

While the Foundations have been successful in attracting the involvement of the Blues and many insurance companies, it is also true that some of the large insurance companies in the United States have not been overly enthusiastic about accepting the challenge of underwriting the broader benefits of Foundation sponsorship.

As more and more Foundations develop around the United States this attitude hopefully will change. The Blues and the insurance industry have much to offer in the way of administrative expertise and fiscal management.

Features of Program

This program has not been finalized. It is still in the negotiation stage. One of the features of the program is elimination of coinsurance and deductibles for medical care beneficiaries in this area in ad-

vance of implementation, really an HMO strategy. The legislative proposal on HMO's does stipulate that the deductibles and coinsurance be abolished commensurate with the provision of full comprehensive health services by an HMO. It also specifies that the HMO may change the actuarial equivalent to enrollees.

In an FMC, consumers' health dollars are protected and high-level quality care is reassured by the very fact that the Foundation is the disbursing agent not only for Medicaid and for other contracts with which it has prepayment arrangements, but conventional insurance plans administered through the Foundation. By computerized processes aberrant cases are punched out on a day-to-day basis analyzed against predetermined norms.

Quality Review

The medical quality review is stacked up against what in the judgment of the appropriate committees of participating physicians are standard norms of medical care. The "usual and customary" fee concept is used and the criterion which serves as the barometer is the Relative Value Study which was developed in California.

Retrospective hospital utilization review is a potentially efficient method of determining over and under stays and inappropriate admissions. However, the retrospective evaluation of hospital utilization is quite awkward when it comes to actually bringing about change in patterns and usage.

Foundations are acquiring added dimensions in their development of more sophisticated expertise in the managerial aspects of the health system. Similarly in the context of the "gaps in health services" the Foundations are asserting leadership in devising methods for providing services in unfilled areas of need.

To accomplish this is no mean effort and Foundations are going through a dramatic period of growth. The physicians who have inspired all of this activity are practicing M.D.'s who are perhaps running themselves into early graves in their now nationally recognized effort to encourage establishment of more and more physician-managed health organizations.

The parent organization for Foundations had until recently been the United Foundations for Medical Care, but more recently board approval was given for the establishment of a new national organization, the American Association of Foundations for Medical Care. The president is Dr. Donald C. Harrington of Stockton, San Joaquin Foundation. Board members are Dr. John Wood of Denver, Colorado State Foundation; Dr. Fredrick W. Dowda of Atlanta, Fulton County Foundation, Georgia; Dr. Ross

Ballard of San Bernardino, San Bernardino Foundation; Dr. Wallace A. Reed of Phoenix, Maricopa County Foundation, and Dr. John Kenney of Santa Rosa, Sonoma County Foundation.

As Foundations attempt to re-evaluate the delivery of health care they must continue to remind

themselves of what is right about the current situation as well as to concentrate on what is wrong. They must continue to measure proposed programs as they relate to the community. For health is truly a community affair.

1004 N. Lincoln Street 95201

CLINICAL CENTER STUDY OF CHILDREN WITH HAND-SCHULLER-CHRISTIAN DISEASE WITH DIABETES INSIPIDUS OR GROWTH RETARDATION

The cooperation of physicians is requested in the referral of children with Hand-Schuller-Christian disease for a study being conducted by the National Institute of Child Health and Human Development's Reproduction Research Branch, at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Of particular interest for this therapeutically oriented study are children with the manifestations of diabetes insipidus or growth retardation of Hand-Schuller-Christian disease.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: Peter O. Kohler, M.D., or Griff T. Ross, M.D., Clinical Center, Room 10-B-09, National Institutes of Health, Bethesda, Maryland 20014. Telephone: (301) 496-4686.

THEY CARE, DO YOU?

All cigarette packs are required by Congressional law to state "Warning: The Surgeon General Has Determined That Cigarette Smoking Is Hazardous to Your Health."

All television networks in the nation, as of last January, do not accept cigarette advertising, which formerly constituted a great portion of their income.

The Georgia Heart Association sponsors county-wide smoking and health programs throughout the state to dissuade young people from taking up this heart-damaging habit.

Concerned health agencies throughout the country, including the Heart Associations, distribute volumes of free anti-smoking literature every year to educate people about the dangers of smoking.

Physicians ask their patients not to start smoking, and if they already have, to give it up.

These and many other sources in the years since cigarette smoking has been proven to be a dangerous risk to your health have given over and over again

of their money, time and concerned effort to make you stop smoking.

They care about you.

How much do you care about yourself?

MAG PRESENTS AWARDS

The Medical Association of Georgia, through its Committee on Allied Health Careers, Chairman, John T. Godwin, M.D., on April 3, presented \$100 and \$50 savings bonds to the best medically related exhibits at the State Science Fair, held at the University of Georgia Coliseum in Athens. Receiving the first prize was David White, age 16, a junior at Baker High School in Columbus for his exhibit of "A Bio-Chemical Analysis of a Cancer Virus." Recipient of the second prize was LaMyra Durrence, age 17, a senior at Glenville High School in Glenville, Georgia for her exhibit of "A Continued Study of the Effect of Amphetamine on *Drosophila, melangoster*."

Foundation for Medical Care

DONALD C. HARRINGTON, M.D.,* *Stockton, California*

IT MAY BE PLEASANT to daydream about rolling history back to the time—if it ever existed—when the only elements in the medical care picture were the physician and the patient. It may be fashionable in some quarters to refer to the third party in medical care as if it were a social disease.

However, excluding the State and other institutional purchasers from the medical care field is about as unlikely as limiting the purchase of stocks to individuals, and eliminating such institutional buyers of stocks as the insurance companies, pension funds, trusts, and mutual funds.

I believe it is safe to say that institutional purchasers of medical care are here to stay and that they will grow in size and importance rather than wither away in the foreseeable future.

The question for the future—the basic challenge for all parties—is this: can these diverse interests find a satisfactory way of life, with the patient realizing the benefits of modern medical care; the physician achieving the professional, psychological, social and financial rewards related to his contribution to the community; the institutional purchaser having increasing assurance that needed medical care funds are well spent; and the organized medical profession having the increasing satisfaction that standards of medical care are being progressively improved?

Over the past several years labor, management, and trust funds (the organized consumers) have been quite vocal in stating their desires for comprehensive coverage and predictable costs.

Labor's main interest has been in the comprehensiveness of coverage. Management, and the trust funds, have been more interested in cutting down the continual spiral of medical costs.

These desires of the organized consumers have resulted in responses from certain organized producers such as Kaiser, HIP, Ross Loos, Group Health of Washington, D.C., and many others. The consumer himself has, in many instances, organized to cover his medical needs as note the United Mine Workers and other labor-management health centers and hospital systems.

Governmental Consumption

The government at all levels—city, county, state, and federal—is a consumer of medical care. Up to

now in very few instances have governmental needs for medical care been able to be covered under any insured programs. More recently the Federal Employees and, in California, the State Employees, as well as the employees of many counties and cities are covered by the insurance mechanism.

In Medicare and Medicaid the government becomes probably the world's largest purchaser of medical care.

In any community the need for a Foundation is directly proportional to the pressures listed above.

Foundation Structure

The Foundation for Medical Care is a wholly owned non-profit corporation controlled by the county medical society. It has two types of members—(1) the participating members who agree to the fee schedule and contracts designed by the Foundation, and, (2) the administrative members who are, in fact, the board of directors of the county medical society.

These administrative members elect a board of trustees to actually manage the affairs of the Foundation. The members of this board have a tenure of three years.

The board is empowered to accept contracts developed by insurance companies for participation by the participating members. The participating members have the final word on the fee schedules under which they will work.

Foundations have spread rather rapidly in California. At the present time there are active Foundations in 36 counties. Foundations have also been formed from Hawaii to Syracuse, New York. There is now an American Association of Foundations for Medical Care to aid in communications from county to county and state to state. An annual conference is held.

Beliefs

The Foundation is patient oriented. We believe deeply that what provides the best medical care for the patient will, in the long run, be best for the medical profession. We do not believe that the solo practice of medicine and the fee for service concept are as "dead as a Dodo."

Conversely, we believe that properly controlled and administered they are capable of producing the highest quality of medical care.

* Medical Director, San Joaquin Foundation for Medical Care.

I would like to emphasize that in my opinion it is the responsibility of each county medical society to be aware of, and responsive to, the economic problems of the population that comprise their patients. This responsiveness may vary from a simple committee action to a full Foundation program with a claims office and many available medical care programs.

The fact that in most Foundations that are in operation there are from 90 to 98 per cent of the practicing physicians in the community enrolled as members attests to the response of the local medical profession to the program.

Acts as Catalyst

The Foundation is not an Insurance Company. It acts as a catalyst for medical care programs, setting fee schedules and medical care standards, which if incorporated into insurance programs will be accepted as full payment by the participating physicians.

At first the insurance industry did not welcome the Foundation movement with open arms, inasmuch as they could see considerable difficulty in implementing programs that would match Foundation standards. As the years have passed, the advantages of claims review and leveling of the spiral of costs that have resulted in Foundation programs, have made more and more insurance companies study this program more thoroughly.

Both labor and management have been extremely complimentary in their comments about the Foundation, both as to the care given and the costs resulting. However, in order to "control and administer" the private practice of medicine and still maintain the freedom of choice of physician and the fee for service concept, certain philosophies and administrative devices must be analyzed.

I wish I could believe that organized medicine could survive by simply endorsing the indemnity concept. However, I am convinced that the desires of the consuming public as illustrated by their turning to comprehensive total coverage in the Federal Employees program, by labor moving to Kaiser and HIP, and by the building of labor health centers and community health associations, point clearly to the need for utilizing the "service concept" in the providing of medical care by the profession.

Controlled Fees

As much as physicians all dislike the concept of controlled fees, I think the time has come when the consumer's demand for predictable medical costs will require that either equitable fee schedules be developed or that the medical profession, through its administrative areas, develop satisfactory methods for controlling overpricing by physicians and yet

maintain the "usual, customary, and reasonable" fee concept.

It is self-evident that fees vary from community to community and in larger communities from neighborhood to neighborhood. It is this variation that has caused the tremendous difficulty in developing state and nationwide contracts. However, with the present concepts of local peer review attuned to the use of centralized EDP equipment, these problems should be solved.

The control of quality is the most important single undertaking that organized medicine can carry out in developing a health care program. This is something that cannot be done by insurance companies, agencies, salesmen, or brokers.

The first step in the quality control of a medical care program is adequate claims review. This is done by individual physicians going over individual claims. Claims that are in question are then reviewed by the claims review committee, decisions as to payment are then made by this committee and are binding upon the physician-members.

Claims review by the profession leads to discipline by moral and social pressure, by letters to physicians, and finally by personal contact between physicians and the review committee.

Quality control has been going on in the hospital for some time with the work of the tissue and medical audit committees; the medical society has carried on this work with the medical ethics committee and the public service committee.

By these activities we feel we have made the cost of medical care predictable to the consumer and have increased the quality of medical care rendered.

Comprehensive Care

Over the years Foundations have developed comprehensive programs of health care which have provided a type of coverage and service which has been greatly instrumental in spreading the Foundation philosophy throughout the nation:

A. "Basic" programs that encompass out-patient home and office calls, consultations, diagnostic x-ray and laboratory; in-patient medical and surgical.

B. "Major Medical" programs usually with the \$50 deductible and 20 per cent coinsurance by the patient.

C. Basic programs with a corridor followed by a superimposed major medical.

D. Individual and family programs. These include mostly in-patient medical, surgical, with out-patient consultations, diagnostic x-ray and laboratory.

E. Programs in which the physicians assume risk. These programs, though few in number, in-

FOUNDATION / Harrington

clude one of the first contracts in which the Foundation became involved, the International Longshoremen and Warehousemen Union and the most recent and most massive contract, Medicaid. In these contracts the Foundation for Medical Care assumes on a fixed premium basis the responsibility of paying for all professional services for the contract period of time. Because of California law, hospitalization and drug services cannot be assumed and must be contracted out to one of the insurance carriers.

All of the above programs have elements of co-insurance and deductibles included in the contract.

Establishment of the San Joaquin Foundation for Medical Care in 1954 has brought about 17 years of experimentation and innovation for the physician members of the Foundation. With virtually all of the medical society's doctors participating in the Foundation, the various standard and experimental programs have brought a certain vitality to the overall practice of medicine in our community which I am sure would not have been there otherwise.

Effect on Medicine

It is difficult to accurately zero in on specific

effects the Foundation has had on the practice of medicine in our area, but of two things I am certain. We have a number of young doctors now practicing in the area who admit they were attracted to practice here because of the innovative approach we attempt. And we have a serious shortage of physicians because, through our overall Foundation approach, we are getting more and more patients into the mainstream of medical care.

The four-county area which the San Joaquin Foundation serves has a total population of some 350,000 persons. Through the Foundation's various private and governmental programs, including Medicare and Medicaid experimental projects, nearly one-half of the population is served medically by the Foundation.

I think one of the most important results of the past 17 years of Foundation experience is peer review. In peer review we are not reviewing for dollar savings, we are reviewing for proper utilization. But, we have discovered conclusively that good quality medicine costs no more, and in many instances it costs less, than poor quality medicine. This benefits recipient and provider alike and, in the last analysis, is what Foundations are all about.

1004 N. Lincoln Street

FOURTH ANNUAL COMMITTEE CONCLAVE

August 7-8, 1971

Sheraton Biltmore Hotel

Atlanta Georgia

Plan to Attend!

GEORGIA MEDICAL CARE FOUNDATION

MINIMUM STANDARDS FOR FOUNDATION SPONSORED

BASIC GROUP INSURANCE PROGRAMS

Effective February 1, 1971

GENERAL AND ADMINISTRATIVE

1. These minimum standards shall apply to all groups written within an effective date on or after February 1, 1971. Payment of benefits shall be in accordance with the usual, customary, or reasonable fee concept.

2. All contracts written will include payment for both in-patient and out-patient services on the basis of the provider's usual, customary, or reasonable fees.

3. Contracts may be written to cover only the subscriber, providing that the contracts meet the minimum standards. If dependents are included in coverage, their coverage must at least meet the minimum standards, however, they may have fewer benefits than the subscriber.

4. Claims reviewed by the Foundation:

The Foundation must receive all claims for review. These claims will be processed by the Foundation and drafts executed under draft authority from the various underwriters.

The Foundation shall be paid a percentage of the Group's Accident and Health premium for processing claims and executing drafts. For this service the Foundation is to receive 5% of the premium. This fee should be paid to the Foundation on a monthly basis as the premium is received from the group. The percentage of premium applies whether or not the Foundation has draft authority. If the underwriter wishes the Foundation to be responsible for certification of eligibility, the Foundation will perform this function.

Claim forms and other forms used for the underwriters shall meet with Foundation approval.

During the contract year if the Foundation is not allowed to keep the original claim file for a reasonable time, the underwriter must reimburse the Foundation for the cost of duplicating the file.

5. Professional payments to be restricted to duly licensed:

A. Physicians and surgeons (doctors of medicine and doctors of osteopathy)

B. Doctors of dentistry

6. No program shall be deemed to meet the Georgia Medical Care Foundation's specifications unless the proposal is accompanied by a letter of approval from the Foundation or a letter from an insurance company or service plan stating the plan meets the Foundation's standards. If granted, such approval shall be for a period of one year and a copy of the proposal shall be filed with the Foundation. If an insurance company wishes to file with the Foundation a letter stating that all proposals from the insurance company purporting to meet the Foundation's specifications do, in fact, meet the Foundation's specifications such a blanket letter will take the place of individual approval of each and every proposal.

7. Annual review of the program for Foundation approval must be secured prior to the renewal date of the contract. Any proposed rate changes should be made known to the Foundation at the time the underwriter seeks this annual approval. The insurer will automatically give the Foundation at the start of each policy year the number of dependents covered, and an estimate of the number of dependents covered, and an estimate of the expected annual premium income and will provide copies of the periodic experience report normally provided to the brokers, agents and/or group.

8. If minimum standards for the Foundation sponsorship are met and the Foundation endorses the program, participating members of the Foundation thereby agree with the following:

To accept as payment in full fees determined to be their usual, customary or reasonable charges. This includes such situations as occur when a non-covered service is provided, a deductible must be met by the patient or co-insurance is available. This applies to both the subscribers and his dependents covered by the Foundation plan.

If the patient or his family has multiple coverage, i.e., other insurance policies which will indemnify the insured for professional services regardless of payment made by Foundation sponsored programs, a participating member of the Foundation has the

right and privilege to charge the patients his usual, customary, or reasonable fee. It is the responsibility of the patient to make known at the initial visit the assistance of other possible additional insurance which may provide coverage. Payment for services received under multiple coverage will be made on the basis of the provider's usual, customary, or reasonable charges and in no instance will exceed such charges.

The Georgia Medical Care Foundation, in sponsoring any program, expects full cooperation by patients in the payment of co-insurance and deductibles of the contract and payment for those items which are not covered.

It is the responsibility of the patient to ascertain in each instance whether or not a doctor is a participating member of the Foundation, either by requesting this information from the doctor or from the Medical Care Foundation offices.

MEDICAL COVERAGE—REQUIRED

1. Coverage for dependent children must start at birth. Coverage for routine neonatal care is recommended at a minimum of \$10.00.

2. Consultation requiring limited examination of given system but not requiring a complete diagnostic history and examination, home, office or hospital (CPT 90600).

3. Consultation requiring more extensive examination, but not requiring complete diagnostic history and examination, home, office or hospital (CPT 90610). This is to include one psychiatric consultation for the purpose of determining whether a disease process is functional or organic, when referred by a participating member of the Georgia Medical Care Foundation (CPT 90610).

4. Consultation requiring complete diagnostic history and examination, office, home or hospital (CPT 90620) when referred by a participating member of the Georgia Medical Care Foundation.

5. Consultation of unusual complexity (in excess of scope of services identified by 90600, 90610, or 90620) necessitating diagnostic history and examination, extensive review of prior medical record, compilation and assessment of data, and the preparation of a special report, home, office or hospital (CPT 90630).

6. Detention—prolonged detention with the patient in critical condition or requiring constant care and attention beyond the usual service, per hour (CPT 99040).

7. Professional medical benefits shall be provided on an in-patient hospital basis for the subscriber and each dependent for each and every illness during contract year as determined to be medically necessary, not to exceed \$200 per patient per contract year. The procedures to be covered under this portion of the contract shall include CPT 90200, 90215, 90220, 90240, 90250, 90260, 90270.

8. The Foundation requires for out-patient medical coverage, a \$25 deductible, per patient per contract year.

9. The following procedures shall be covered under the out-patient medical portion of the contract up to a maximum of \$300 per patient per contract year: CPT 90000, 90010, 90020-4, 90030, 90040, 90050, 90060, 90070, 90080-4, 90100, 90110, 90115, 90120, 90130, 90140, 90150, 90160, 90170.

10. It is understood that all procedures not listed may be excluded from the contract but it is further understood that these procedures when performed may be billed directly to the patient.

RADIOLOGY AND LABORATORY COVERAGE

1. All laboratory and x-ray services medically necessary shall be provided, irrespective of whether the patient is in or out of the hospital to a maximum of \$200 per contract year. The following procedures shall also be covered: (Cardiovascular Procedures) CPT 93000, 93005, 93010, 93020, 93025, 93030, 93040, 93045, 93200, 93205, 93220, 93240, 93260, 93500, 93510, 93515, 93520, 93525, 93540, 93550, 93560, 93565, 93566, 93700, 93720, 93725, 93740, 93760, 93770, 93780, (Pulmonary procedures) CPT 94010, 94030, 94060, 94150, 94160, 94200, 94210, 94240, 94280, 94350, 94680, 94681, 94690, 94700, 94705, 94710, 94720, 94750, 94770.

2. A separate benefit will be provided for radiotherapy and radioactive isotope procedures for treatment of illness or injury when deemed medically necessary, up to a maximum of \$500 per patient per contract year.

REQUIRED SURGICAL COVERAGE

1. All necessary surgical procedures shall be allowed on the basis of usual, customary, or reasonable fee basis, up to a maximum of \$1250 per patient per contract year.

2. Coverage for dependent children must start at birth and include circumcision.

3. Ectopic pregnancy and D & C shall be a benefit irrespective of provisions on maternity benefits.

4. The patient's initial cesarean section will be covered on the basis of usual, customary, or reasonable fees.

5. Physician anesthesiologists shall be covered according to their usual, customary, or reasonable charges. Services provided by an anesthetist will be paid in accordance with the usual fee charged by the facility. These fees, to a maximum of \$175 per patient per contract year, shall be in addition to any maximum surgical allowance.

6. Surgical procedures covered in the hospital are likewise a benefit when done on an out-patient basis in the physician's office provided the latter is considered good medical practice in the community by the local Review Committee. A surgical tray charge shall be allowed in these circumstances as part of the \$300.00 miscellaneous hospital allowance and the procedure shall be payable on the basis of the usual, customary, or reasonable charges.

REQUIRED HOSPITAL BENEFITS

1. A minimum of 31 days of hospital coverage must be provided at a minimum rate of \$30.00 per day allowed.

2. \$300.00 will be allowed for miscellaneous hospital charges for the subscriber and each dependent for each period of illness and injury during the contract year. This benefit will also apply for surgery as approved on an out-patient basis in lieu of hospitalization as outlined above in paragraph six of the Surgical Coverage. Technical charges by the hospital for x-ray and laboratory shall be payable as a part of this benefit.

3. Coverage for dependent children must begin with birth, and should include an allowance of \$25.00 for routine nursery care of the newborn well baby.

4. Hospital benefits shall be provided according to the stated limits of the contract for ectopic pregnancy and D & C.

5. Hospital benefits shall apply for an initial cesarean section after a deductible of \$150.00.

6. Hospital service in the hospital's out-patient department shall be covered to the degree accorded in Item Two above.

REQUIRED SUPPLEMENTAL ACCIDENT COVERAGE

1. At least \$300.00 supplemental coverage shall be provided for accident care for subscribers and dependents and payable on the basis of usual, customary, or reasonable charges.

COMPLICATIONS OF PREGNANCY

1. All complications of pregnancy except Items Three and Four of the Surgical Section and Items Four and Five of Hospital Benefits Section shall be covered with a \$600.00 deductible allowable irrespective of what normal maternity benefits will pay.

REQUIRED MATERNITY BENEFITS

1. A minimum of \$100 towards the physician's charges and \$100 towards the hospital charges shall be payable.

GEORGIA MEDICAL CARE FOUNDATION

MINIMUM STANDARDS FOR FOUNDATION SPONSORED MAJOR MEDICAL GROUP PROGRAMS

Effective February 1, 1971

(Refer to Basic Group Insurance Programs)

OUTLINE OF BENEFITS

1. Maximum Limit

The maximum aggregate amount payable for all covered benefits for each patient is \$5,000 during each calendar year or \$10,000 during the lifetime of each patient.

2. Schedule of Benefits

HOSPITAL BENEFITS: At least 80% of the first \$500.00 of expenses of necessary hospital services and supplies during hospital confinement, plus 80% of the remainder. A \$50.00 deductible may also be applied. Hospital daily room and board charges are payable up to the semi-private room rates. Services by physicians and surgeons are not payable under Hospital Benefits.

OTHER COVERED EXPENSES: At least 80% of the \$5,000 of Other Covered Expenses. The patient must pay the first \$50.00 before being eligible for these Other Covered Expenses during each calendar year. This is to include the cost of intensive care and cardiac care units, not to exceed seven days of coverage.

Benefits are payable for medical services, surgery, radiology and pathology on the basis of the usual, customary, or reasonable charges. Recognizing that problems may arise when someone seeks professional attention outside the area covered by the Foundation, the Foundation will allow at least 80% of the usual and customary charges to be paid for services received in an area outside of the Foundation area.

When ordered by a legally qualified physician or surgeon, the Covered Expenses referred to above are for:

A. Treatment by a legally qualified physician or surgeon including expenses which are relative to surgical procedures.

B. Services of a licensed or graduate nurse, other than a person who ordinarily resides in the insured person's home or who is a member of the insured person's immediate family (comprising the insured person's spouse and the children, brothers, sisters, and parents of such insured person's spouse).

C. Anesthetic and its administration.

D. Treatment by a physiotherapist (other than a member of the insured person's immediate family as defined above).

E. Dental treatment by a physician, dentist or dental surgeon for a fractured jaw or for injury to natural teeth including replacement of such teeth within six months after the date of the accident.

F. X-ray or radium treatments.

G. X-ray and laboratory examinations, excluding dental x-rays unless rendered for dental treatment of a fractured jaw or of injury to natural teeth within six months after the date of the accident.

H. Professional ambulance service, except service by a railroad, ship, bus, airplane or other common carrier.

I. Medical supplies:

1. Drugs and medicines dispensed by a licensed pharmacist when prescribed by a licensed physician and surgeon and when for the specific illness or accident for which the patient is being treated.

2. Blood and blood plasma.

3. Artificial limbs and eyes.

4. Surgical dressings.

5. Casts.

6. Splints.

7. Trusses.

8. Braces.

9. Crutches.

10. Rental of wheelchairs or hospital bed.

11. Oxygen and rental of equipment for its administration.

3. Exceptions:

This plan not to cover loss caused by or resulting from:

A. Injury or sickness which arises out of or in the course of any occupation or employment for wage or profit, compensable under the Workmen's Compensation Laws of the State of Georgia.

B. Pregnancy, childbirth or miscarriage, except that in the case of a complication incident to pregnancy, other than a caesarean section for delivery of child or children, the Foundation will pay such expenses which are in excess of those which would have been incurred in the absence of such complications as determined by the Foundation.

C. Declared or undeclared War or any act thereof.

D. Service in the Armed Forces of any country.

E. Cosmetic surgery, except for treatment of injuries sustained in an accident while the insurance is in force as the covered person.

F. Dental treatment, except dental treatment made necessary by injury to sound natural teeth.

G. Eye refractions or the fitting of glasses or hearing aid.

H. Expenses incurred for room and board provided by a hospital for a child during the period the mother is hospital confined as the result of giving birth to such child or expenses incurred for medical examinations and "checkup" purposes except where indicated and necessary to the treatment of an illness of such child.

I. Expenses incurred during confinement in a hospital owned and operated by the United States Government or any agency thereof or for services, treatments or supplies furnished by or at the direction of the United States Government or any agency thereof, unless the treatment occurs in an emergency situation and for which service payment is demanded by the United States Government or any agency thereof.

J. Expenses incurred during confinement in a hospital owned and operated by a State, Province or political subdivision, unless there is an unconditional requirement on the part of the Covered Person to pay such expenses without regard to any liability against other, contractual or otherwise.

4. Psychiatric services shall be covered but may be limited to services while confined in a hospital, and the maximum liability may be reduced to a limit of \$1,500 in the aggregate in respect to each insured person.

ARTICLES OF INCORPORATION OF GEORGIA MEDICAL CARE FOUNDATION, INC.

1.

The name of the corporation is GEORGIA MEDICAL CARE FOUNDATION, INC.

2.

The corporation shall have perpetual duration.

3.

The corporation is a nonprofit corporation organized and to be operated exclusively for the following purposes:

(a) To promote and develop means whereby medical services of all kinds can be provided to the general public, at reasonable cost, and in accordance with proper medical and ethical standards; to study and promote improved methods and facilities for health care and the improvement of the public health; to study and implement means of financing health care, and, in conjunction with medical societies and other professional organizations representing persons engaged in health care, hospitals, nursing homes, the various branches of government, the insurance industry, representatives of management and labor, and other interested persons, to study, promote and establish improvements in means of financing and providing proper medical care; to promote the art and science of medicine and to foster medical education; and to disseminate information to the general public concerning medical science and health care.

(b) To receive and acquire by gift, grant, purchase, devise, bequest, or otherwise, as may be lawful, money and real and personal property of any kind; and to hold, accumulate, invest, or dispose of such property or the income derived therefrom for the furtherance of the above stated purposes.

(c) To do and engage in any and all lawful activities which may be incidental or reasonably necessary to any of the foregoing purposes, and to have and to exercise all other powers and authority now or hereinafter conferred upon nonprofit corporations under the laws of the State of Georgia.

4.

The number and method of election of directors shall be as provided in the Bylaws of the corporation.

5.

The initial registered office of the corporation shall be at 938 Peachtree Street, N.E., Atlanta, Georgia 30309. The initial registered agent of the corporation shall be Edwin F. Smith.

6.

The initial Board of Directors shall consist of three (3) members who shall be:

F. William Dowda, M.D.
490 Peachtree Street, N.E.
Atlanta, Georgia 30308

J. Rhodes Haverty, M.D.
33 Gilmer Street, S.E.
Atlanta, Georgia 30303

John S. Atwater, M.D.
478 Peachtree Street, N.E.
Atlanta, Georgia 30308

The three original members of the Board of Directors shall serve until election of their successors in accordance with the Bylaws of the corporation.

7.

The Medical Association of Georgia, a nonprofit corporation, 938 Peachtree Street, N.E., Atlanta, Georgia, is the incorporator.

8.

The corporation shall have one or more classes of members, who shall have such qualifications and rights as are set forth in the Bylaws of the corporation.

9.

The corporation is not organized and shall not be operated for the purpose of pecuniary gain and profit, and no part of any earnings or profits of the corporation shall inure to the benefit of any member, director or other private individual; provided, however, that reasonable compensation may be paid by the corporation for services rendered to it, and reimbursement may be made for any expenses incurred for or on behalf of the corporation, by any officer, director, member, agent, employee, or other person, firm or corporation; and provided further that the corporation may make payments to or for the benefit of its members in payment for services performed by such members under health and medical care plans promoted, established or administered by the corporation. Moreover, the corporation shall not, as a substantial part of its activities, carry on propaganda or attempt to influence legislation, and shall not participate or intervene in any political campaign on behalf of any candidate for public office.

10.

Upon dissolution of the corporation, whether voluntary or involuntary, no assets of the corporation or benefits by virtue of such dissolution shall be distributed to or received by the directors or members, and any such assets or benefits after payment and satisfaction of all claims and demands against and liabilities of the corporation shall be applied and distributed exclusively for the promotion of such social welfare or charitable purposes as the Board of Directors of the corporation shall determine.

BYLAWS OF GEORGIA MEDICAL CARE FOUNDATION, INC.

ARTICLE I.

Membership

Section 1. Classes of Membership.

There shall be two classes of membership in the corporation, to wit: Administrative Members and Participating Members.

Section 2. Qualifications of Membership.

(a) Administrative Members. The Administrative members of the corporation shall be those persons who are both Participating members of this corporation and members of the Council of The Medical Association of Georgia as provided from time to time in the Constitution and Bylaws of The Medical Association of Georgia.

(b) Participating Members. Any physician licensed by the Composite State Board of Medical Examiners of the State of Georgia shall be eligible to apply for election to Participating membership in the corporation. Admission to Participating membership shall be granted by the Board of Directors of the corporation to any such physician so qualified upon his making proper application therefor. The dues and assessments to be charged for admission to Participating membership and good standing thereafter shall be determined by the Board of Directors.

Section 3. Voting Rights and Privileges of Members.

(a) Administrative Members. The Administrative members shall have the exclusive right to elect the Board of Directors of the corporation and to fill any and all vacancies therein. Matters may be submitted to the Administrative membership either at a separate meeting thereof or at any regular or special meeting of the Council of The Medical Association of Georgia in accordance with its Constitution and Bylaws. A quorum of such members shall be a quorum of the Council of The Medical Association of Georgia as provided in the Bylaws of The Medical Association of Georgia from time to time. The Administrative members, voting as aforesaid, shall have the exclusive power to vote on the following matters:

(i) The election of the original and all subsequent Boards of Directors of the corporation and the filling of any and all vacancies therein; provided that the Executive Committee of Council of The Medical Association of Georgia may fill such vacancies subject to confirmation at the next meeting of the Administrative members; except that the President, President-Elect and Secretary of The Medical Association of Georgia shall automatically be ex-officio members of the Board of Directors;

(ii) The adoption of any schedule or plan of payment and the general type of provision to be contained in contracts to be used by the corporation for medical services to be provided by the Participating members, provided, however, that any such schedule, plan, or contract shall be based upon the concept of the usual, customary, or reasonable fee.

As provided elsewhere in these Bylaws, the Administrative Committee shall have the power to amend, adopt, or repeal the Bylaws of the corporation and to amend the Articles of Incorporation.

(b) Privileges of Participating Members. Except as stated hereafter, Participating members shall have no right to vote with respect to any matter or thing submitted to the members, or with respect to the election of the Board of Directors of the corporation. Participating members shall have the privilege of holding any office in the corporation unless restricted by any other Bylaw of the corporation, and the privilege of membership on any committee of the corporation. Participating members shall also have the right, by a majority vote of those Participating members voting, to amend, adopt, or repeal the Bylaws of the corporation and to amend the Articles of Incorporation. On any such issues submitted to the Participating members for vote, each Participating member shall be entitled to one vote.

(c) Proxy Voting and Voting by Mail. Voting by proxy or by mail is expressly prohibited for either class of membership.

Section 4. Term of Membership.

Participating membership in the corporation shall be for one (1) year. Subject to the procedure hereinafter provided, the termination date and the method for renewal of the term shall be determined by the Board of Directors.

Section 5. Procedure for Admission to Participating Membership.

Any physician qualifying for Participating membership in the corporation shall fill out and sign an application blank provided for that purpose by the corporation, which shall be in such form as determined by the Board of Directors. Such application shall contain a clause stating in substance that the applicant agrees to be bound by the corporation's Articles of Incorporation, Bylaws, and rules and regulations adopted from time to time. The membership application shall be filed at the corporation's principal office with the Secretary, who shall then refer it to the Board of Directors, or if a membership committee has been appointed for that purpose, then to such committee, for investigation of the qualifications and status of the applicant. The Board of Directors shall consider the approval of such application and any membership committee recommendation thereon. Applicants shall be elected to membership by a majority of the Directors then serving in office. At the end of the term of membership, Participating members shall automatically be renominated for re-election to the membership, unless the Board of Directors shall otherwise direct. If a membership committee has been appointed as above specified, the membership committee may recommend to the Board of Directors that a member not be re-elected, and in such event, or if the Board itself desires to take such initiative, the procedures established in Article VII of these Bylaws shall apply as if a complaint had been filed under said Article VII.

Section 6. Nontransferability of Membership.

Participating membership in the corporation shall in no event be transferable or assignable in any form, either by voluntary or involuntary act or by operation of law. In the event of the death or incapacity of any member or any attempted transfer or assignment of membership, the membership, membership certificate and all interest of such member in the corporation shall be forthwith cancelled and revoked.

Section 7. Membership Roll.

A written record of the Participating membership of the corporation shall be maintained by the Secretary. Such records shall contain the name and address of each Participating member, and in any case where a membership has been terminated or cancelled, shall contain an entry of such fact and the date of such termination or cancellation.

Section 8. Certificates of Membership.

Certificates of Participating membership may be authorized for distribution to the Participating members in such form as the Board of Directors may from time to time prescribe. Provided, however, each such certificate shall expressly state on its face the name of the physician to whom it is issued, a statement that it is nontransferable, and the date of expiration of the term of membership. Issuance to and acceptance by a Participating member of such certificate shall be conclusive evidence of the consent of such member to become a Participating member of the corporation and of his agreement to comply with and be governed by all provisions of the corporation's Articles of Incorporation, Bylaws, and the rules and regulations.

ARTICLE II.

Meetings of Members

Section 1. Annual Meetings.

The annual meetings of the Administrative and Participating members of the corporation shall be held at such time and date as shall be determined by the Board of Directors and shall be held at such time, date, and place as may be convenient to members of The Medical Association of Georgia attending the annual session of members thereof, or at such other time, date, and place as may be determined by the Board of Directors and designated in the notice of said meeting, for the purpose of

the election of Directors by the Administrative members, and for the transaction of such other business as may be properly brought before the meeting.

Section 2. Special Meetings.

Special meetings of either class of membership shall be held at the principal office of the corporation, or at such other place as may be designated in the notice of said meetings, upon call of the Board of Directors or of the President, and shall be called by the President or the Secretary at the request of at least twenty-five per cent (25%) of the members of the class of which the meeting is requested. Any such request of members shall state the purpose or purposes for which meeting is to be called.

Section 3. Notice and Purpose of Meetings.

Written notice of the time and place of every meeting of members, and in the case of a special meeting, of the purpose or purposes of such meeting, shall be given either personally or by first-class mail, not less than ten (10) nor more than fifty (50) days before the meeting, to each member of the class for which such meeting is called. If mailed, such notice shall be directed to each member at his address as it appears upon the records of the corporation. Any notice given by mail shall be deemed to have been given on the date deposited with first class postage paid. A member may waive notice of any meeting by attendance at the meeting, or by so stating in writing, either before or after the meeting. Notice of any adjourned meeting of members shall not be required to be given.

Section 4. Quorum.

Fifteen per cent (15%) of the Participating members shall constitute a quorum at any meeting of Participating members. The quorum for a meeting of the Administrative members shall be the same as a quorum for a meeting of Council of The Medical Association of Georgia as specified from time to time in the Bylaws of The Medical Association of Georgia. In the absence of a quorum at any meeting or any adjournment thereof, a majority of the members present may adjourn such meeting from time to time. At any such adjournment at which a quorum is present, any business may be transacted which might have been transacted at the meeting as originally called.

ARTICLE III.

Directors

Section 1. Governing Board.

The property, affairs, and business of the corporation shall be managed and directed by the initial Directors specified in Article 6 of the Articles of Incorporation who shall serve until the meeting of the Administrative members and thereafter by its Board of Directors, consisting of eleven (11) persons, who shall be elected by the Administrative members from the Participating membership in the manner prescribed in Section 3(a) of Article I except for the ex-officio members; provided, however, that the Board of Directors shall at all times include at least nine (9) Directors who were at the time their particular term as a Director commenced one of the following: any officer of The Medical Association of Georgia, any member of the Executive Committee of Council of The Medical Association of Georgia, any Councilor or Vice Councilor of The Medical Association of Georgia, or any Delegate or Alternate Delegate to the American Medical Association. Each member of the Board shall be engaged in the active private practice of medicine at all times while serving on the Board, except that this shall not apply to the ex-officio members of the Board.

Section 2. Term.

Each member of the Board of Directors shall serve for a term of three (3) years and until his successor is elected by the Administrative members and is qualified to serve, except for the ex-officio members who shall serve their term consequently with their term of office in The Medical Association of Georgia.

Section 3. Vacancies.

Vacancies in the Board of Directors, for any reason, shall be filled for the unexpired term or terms with a successor or successors elected by the Administrative members.

No vacancy in the office of a Director shall impair the right of the Board of Directors to exercise all of its rights and perform all of its duties.

Section 4. Executive and Other Committees.

The Board of Directors may by resolution designate from among its members an executive committee, and from among the Participating membership one or more other committees, each consisting of three (3) or more persons. The Executive Committee, to the extent provided in such resolution, shall have and may exercise any or all of the authority of the Board of Directors, except as may be restricted by law for nonprofit corporations. Any other committees shall have such powers and perform such duties as the Board may prescribe. Any committee shall act by a majority vote of its members.

Section 5. Rules and Regulations.

The Board of Directors shall adopt, from time to time, such rules and regulations not inconsistent with the corporation's Articles of Incorporation or Bylaws, as it deems advisable for the conduct of its activities and the promotion of its purposes.

ARTICLE IV.

Meetings of the Board of Directors

Section 1. Date.

The Board of Directors shall meet annually at such time and date as it shall determine following the annual meeting of the members of the corporation, for the purpose of transacting any and all business that may properly come before the meeting. If the annual meeting is not held as herein provided, any business which might properly have been acted upon at that meeting may be acted upon at any subsequent meeting held pursuant to these Bylaws. Other meetings may be scheduled to occur at regular intervals throughout the year. Special meetings of the Board of Directors shall be held whenever called by the President or, in his absence, the Secretary of the corporation, or by any three (3) Directors then in office.

Section 2. Place.

The Directors may hold their meetings at any place as set forth in the notice of the meeting or, in the event of a meeting held pursuant to waiver of notice, as may be set forth in the waiver.

Section 3. Notice.

Unless waived as contemplated in Section 4 of this Article IV, the President or the Secretary of the corporation or any three (3) Directors shall give notice to each Director of each special meeting stating the time and place of the meeting. Notice of any meeting of the Board of Directors need not state the purpose of, nor the business to be transacted, at any such meeting. Such notice shall be given by telephone, telegraph, or personal visit at least three (3) days before the meeting, or by written notice deposited in the United States mail first-class postage paid addressed to each Director not less than seven (7) days before the meeting. No notice shall be required for any annual or other regularly scheduled meeting of the Directors of the corporation.

Section 4. Waiver of Notice.

Meetings may be held at any time without notice, if all the Directors are present, or if at any time before or after the meeting those present waive notice of the meeting in writing.

Section 5. Quorum.

A majority of the members of the Board of Directors then in office shall constitute a quorum. The act of a majority of such Directors present at a meeting at which a quorum is present shall be the act of the Board of Directors. If at any meeting of the Board of Directors there shall be less than a quorum present, a majority of those present may adjourn the meeting, from time to time, until a quorum is present, without further notice to either the Directors present or those absent.

Section 6. Action Without a Meeting.

Any action required or permitted at a meeting of Directors may be taken without a meeting if written consent, setting forth the action so taken, shall be signed by all of the Directors and filed with the Minutes of meetings of Directors of the corporation.

ARTICLE V.

Officers

Section 1. Number.

The officers of the corporation shall be a President, who shall be chosen from among the Directors, a Vice President, a Treasurer, and a Secretary. In addition, there may be other Vice Presidents, an Executive Director (who may automatically be the Executive Director or any Assistant Executive Director of The Medical Association of Georgia, if so designated), an Assistant Secretary, and such other subordinate officers as the Board of Directors may deem necessary from time to time. Any two or more offices may be held simultaneously by the same persons, except that no one person shall simultaneously hold the offices of President and Secretary.

Section 2. Term of Office.

The principal officers shall be chosen annually by the Board of Directors at the annual meeting of the Board, or as soon thereafter as is conveniently possible. Subordinate officers may be elected from time to time. Each officer shall serve until his successor has been elected or appointed and has qualified, or until his death, resignation, or removal.

Section 3. Vacancies.

Any vacancy in an office resulting from any cause may be filled for the unexpired portion of the term thereof by the Board of Directors.

Section 4. Removal.

Any officer may be removed from office at any time the Board of Directors in its judgment determines such removal to be in the best interest of the corporation, by the affirmative vote of a majority of the members of the Board of Directors then in office.

Section 5. Powers and Duties.

Except as hereinafter provided, the officers of the corporation shall each have the powers and duties as generally pertain to their respective offices, as well as such powers and duties as from time to time may be conferred by the Board of Directors.

(a) The President shall be the Chairman of the Board of Directors and the Chief Executive Officer in charge of the operations of the corporation, shall have general supervision of the corporation, and shall preside at all meetings of the Board of Directors and of the Administrative or Participating members. He shall sign all notes and obligations of the corporation as directed by the Board of Directors and generally shall perform all duties usually incumbent upon the Chief Executive Officer and such as may be required of him by the Board of Directors.

(b) The Vice President shall exercise the functions of the President during the absence or disability of the President, and shall have such other duties as are granted, conferred and assigned to him from time to time by the Board of Directors.

(c) The Secretary shall perform such duties as are incident to his office and as may be assigned to him from time to time by the Board of Directors or these Bylaws. The Assistant Secretary shall in the absence of the Secretary perform the duties and exercise the powers of the Secretary, and shall perform such other duties as may be assigned by the Board of Directors.

(d) The Treasurer shall have the custody of the corporate funds and securities and shall keep full and accurate accounts of receipts and disbursements in books belonging to the corporation and shall deposit all monies and other valuable effects in the name and to the credit of the corporation in such depositories as may be designated by the Board of Directors. He shall disburse the funds of the corporation as may be ordered by the Board, taking proper vouchers for such disbursements, and shall render to the President and the Board, at its regular meetings, or when the Board

so requires, an account of all his transactions as Treasurer and of the financial condition of the corporation. If required by the Board, he shall give the corporation a bond at the corporation's expense, in such sum and with such surety or sureties as shall be satisfactory to the Board for the faithful performance of the duties of his office and for the restoration to the corporation, in case of his death, resignation, retirement or removal from office, of all books, papers, vouchers, money, and other property of whatever kind in his possession or under his control belonging to the corporation.

(e) Other subordinate officers appointed by the Board of Directors shall exercise such powers and perform such duties as may be delegated to them by the resolutions appointing them, or by subsequent resolutions adopted by the Board of Directors from time to time.

ARTICLE VI.

Indemnification of Directors and Officers

The corporation shall indemnify the Directors and officers of the corporation, and may purchase and maintain liability insurance on behalf of such Directors and officers, under the conditions of, to the extent provided in, and subject to the limitations of Sections 22-2611 and 22-717 of Georgia Code Annotated.

ARTICLE VII.

Discipline and Expulsion of Members

Section 1. Committee.

The Board of Directors shall appoint a committee to act upon matters of discipline and expulsion of members. Such committee shall have such number of members and shall conduct its proceedings as specified by the Board of Directors. Such committee is hereinafter in this Article VII called "the Committee."

Section 2. Action on Complaint.

The Committee shall investigate all complaints submitted in writing against a member of the corporation. A "complaint" subject to investigation by the Committee shall be in writing signed by a patient, guardian of a patient, member of the patient's family, or any person having financial responsibility for the support of a patient, or by another member of the corporation, or any public official of municipal, county, state or United States Government, or by any responsible official of any company providing medical benefits to patients through members of this corporation, alleging that the member against whom the complaint is filed is guilty of unethical or illegal behavior against a patient or society indicating that such member should be disciplined, received by the corporation or the Committee.

The corporation and the Committee shall have no jurisdiction of a complaint which merely seeks compensation from or criticism of a member for malpractice not constituting unethical or illegal behavior.

Section 3. Procedure on Receipt of Complaint.

The Committee, upon receipt of a complaint, shall send a copy of the complaint, by registered or certified mail with return receipt requested, to the member against whom the complaint is lodged. The member shall be notified at that time that he has thirty (30) days after his receipt of the complaint to file a written answer to the complaint with the Committee. The member shall also be notified that if he fails to file a written answer to the allegations in the complaint within the thirty (30) day period, the Committee may consider the allegations to be admitted.

Within sixty (60) days after receipt by the Committee of the written answer from the physician against whom the complaint was lodged, or if the member against whom the complaint has been lodged does not respond within the thirty (30) day period, the Committee will either:

(a) Dismiss the case because of insufficient grounds to substantiate a legitimate complaint, notifying both parties of this decision; or

(b) Convene a hearing, notifying both parties in writing, by registered or certified mail with return receipt requested, of the hearing at least fifteen (15) days in advance of such hearing.

Section 4. Procedure at Hearings.

Attendance at such hearings shall be limited to members of the Committee, staff of the Committee, and legal counsel assigned to assist the Committee, if any; witnesses, if any; the complainant and his legal counsel, if any, and the member against whom the complaint has been lodged and his legal counsel, if any. Parties, their counsel, Committee members, and staff may call and cross-examine witnesses, introduce evidence reasonably germane to the issues, and enter objections to testimony and material offered in evidence. The Committee shall not be bound by the rules of evidence usually employed in legal proceedings but may accept any evidence they deem appropriate and pertinent. Should any party to the controversy fail to appear at the hearing, the Committee may, at its discretion, continue, dismiss, or proceed with the hearing. A majority of all members of the Committee in office shall constitute a quorum for the transaction of business of the Committee and action may be taken upon the vote of a majority of Committee members present at any meeting at which a quorum is present. The Committee may designate three (3) or less members to constitute hearing officers at the hearings on complaints specified herein.

Section 5. Further Procedure.

At the conclusion of the hearing, or the hearing officers' report, the Committee shall meet with its staff and legal counsel, if any, assigned to assist the Committee, in closed session, and render a report in writing containing its findings and conclusions and recommendations, if any, to the Board of Directors of the corporation. All parties of record and their legal counsel shall be notified that the report has been submitted to the Board of Directors for its action. The Committee in its deliberations shall have a choice of one of the four following dispositions:

(1) Dismiss the case because of insufficient grounds for a legitimate complaint as defined above;

(2) Attempt a satisfactory reconciliation of the parties involved;

(3) Suggest to the member changes in his conduct and relationship with his patients or others;

(4) Refer to the Board of Directors of the corporation all cases in which action by the Board of Directors is deemed necessary with the recommendations of the Committee as to disciplinary actions to be taken by the Board of Directors. The Committee may recommend, and the Board of Directors may take (whether or not recommended by the Committee) any one or more of the following actions:

(i) Dismiss the complaint;

(ii) Censure the member in writing by registered or certified mail, return receipt requested, and notify all other parties of record and their counsel of such action;

(iii) Censure the member before the Committee at a meeting, notice of which has been given by registered or certified mail, return receipt requested, to parties of record and their legal counsel;

(iv) Suspend the member from membership in the corporation without refund of dues for a period certain not to exceed one year; or

(v) Expel the member from membership in the corporation without refund of dues. Expelled members shall not be entitled to reinstatement to membership until two (2) years from the date of expulsion.

(vi) Notification of any action of the Board of Directors under Items (i), (iv), and (v) above shall be sent by registered or certified mail, return receipt requested, to all parties of record and legal counsel.

ARTICLE VIII.

Miscellaneous

Section 1. Fiscal Year.

The fiscal year of the corporation shall be such period as the Board of Directors shall determine.

Section 2. No Right to Earnings or Property.

No member, Director, or officer shall be entitled to any of the property or earnings of the corporation. These shall be used exclusively for the purposes set forth in the Articles of Incorporation of the corporation.

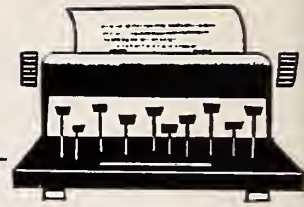
Section 3. Corporate Seal.

The seal impressed below is hereby adopted as the corporate seal of the corporation. In the event it is inconvenient to use such seal at any time, the signature of the corporation followed by the word "Seal" enclosed in parentheses shall be deemed the seal of the corporation.

ARTICLE IX.

Amendments

These Bylaws may be amended, altered or repealed, and the new Bylaws adopted, by a vote of the Administrative members as provided in Section 3(a) of Article I hereof, or by a vote of the Participating members as provided in Section 3(b) of Article I hereof, or by a vote of at least two-thirds of all the Directors present at any duly held meeting; provided, however, that the Directors shall not have the right to alter or repeal any amendment hereto or new Bylaws adopted by the Administrative members or the Participating members if the Administrative members or the Participating members in the resolution of such alteration, repeal, or adoption of new Bylaws have specified that such action shall not be changed by the Board of Directors. The Administrative members and the Participating members shall, however, have the right to amend any Bylaw adopted or altered by the Board of Directors and the Administrative members shall, however, have the right to amend any Bylaw adopted or altered by the Participating members. In no event, however, shall any amendment, alteration, or new Bylaw be adopted which would operate in any way to make this corporation no longer an exempt corporation for tax purposes within the purview of the relevant Federal and State statutes.



The Foundation Needs You!

You Need the Foundation!

THE PAGES OF THIS ISSUE of the *Journal of the Medical Association of Georgia* have been devoted to an in-depth look at Foundations for Medical Care and, specifically, at the Georgia Medical Care Foundation. Of course, not all the questions about the Foundation can be answered here nor can they be answered in the immediate future unless the Foundation has an opportunity to prove itself. This opportunity can only be provided by the physicians of Georgia.

Through the active support and participation of every physician in this state, the Georgia Medical Care Foundation could become a vigorous and responsive organization designed to protect and serve the economic interest of its members. Through its negotiations with third party payers—private and governmental, the Foundation would endeavor to assure its members compensation for their services on the basis of the usual, customary or reasonable fee concept. In working with Medicare and Medicaid, Foundation policy demands an equitable system of payment to physicians based on current data with an allowance for increases in fees on a reasonable basis. As Foundation membership expands and the Foundation achieves a position of strength from which it can deal effectively through its members, with providing quality medical care to groups covered under contract through private or government insurers, benefits will accrue not only to the physician members but also to the insurers and the consumers.

Both nationally and locally, representatives of the health insurance industry have expressed grave concern over the increasing deficits faced by their companies in providing health insurance coverage. In meetings with the Foundation, they have been eager to discuss a means by which some control could be exerted over the spiraling cost of health care. This (the Foundation), through its member physicians, can provide, by its peer review system which assures not only the monitoring of charges with review of those deemed excessive but also an evaluation of the care provided, to insure the highest quality of medical care by reviewing the degree of the utilization of services. As professionals, physicians are best qualified to evaluate and judge the adequacy of care being provided by a fellow physician. And, as professionals with a responsibility to their profession, physicians recognize their duty to review the services provided by a fellow physician. By pledging ourselves to the purposes of the Foundation and accepting the responsibility and duty of peer review by physicians for fellow physicians, we shall prove our commitment to providing quality medical services at reasonable cost to those in government, in the health industry, and among consumer groups who have doubted our veracity and reviled our profession.

As in any such endeavor which affects the provision of health care, the interest of the public must be kept foremost in mind. The Foundation plan is not a panacea for the problems of health care delivery nor is it the final answer to the demands of the public. The Foundation offers to the public through its membership in a covered group greater accessibility to medical services, better assurance of quality of care and more control over the cost of services. As the Foundation grows and gains experience, the coverage plan available to groups would be expanded and improved with one goal being the provision of comprehensive health care.

As members of the Medical Association of Georgia, you had been notified of the extension of membership in the Foundation to you through May. Now, it is time for each physician to renew his membership in the Foundation by signing the form which follows and returning it to the MAG Headquarters office. Remember, through the Foundation the physicians of Georgia will be able to shape their own destiny; no matter if the government requires Professional Standards Review Organizations, Health Maintenance Organizations or similar programs, the Foundation will stand ready!

The time for action is now, while national health insurance and socialized medicine are but spectres. Through the united effort of Georgia physicians, the Georgia Medical Care Foundation can serve as an alternative method of health care delivery.

These brief facts should serve to summarize the meaning and purpose of the Georgia Medical Care Foundation.

WHAT IS IT?

- A. Voluntary association of physicians organized to provide medical care to individuals enrolled in Foundation sponsored health plans.
- B. Arm of Medical Association, designed to assist physicians in dealing with third party payment for medical services.
- C. Endeavor of organized medicine to continue to provide necessary medical care of high quality and at reasonable cost.

(Continued on next page)

GEORGIA MEDICAL CARE FOUNDATION, INC.

I agree to continue membership and to support the Bylaws, Articles and philosophy of the Georgia Medical Care Foundation, Inc., for the fiscal year, June, 1971 to June, 1972.

NAME (please print) _____

ADDRESS _____

DATE _____

SIGNATURE _____

Mail to MAG Headquarters Office, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

PRESIDENT'S LETTER



INTRODUCTIONS

LET ME ASSURE YOU that I am deeply grateful for the honor that you have bestowed upon me, and that I appreciate fully the responsibilities that this high office entails. This is not an empty honor, but a big job, and I propose to put into it all that I have of energy and ability. It does make one feel most humble when his colleagues see fit to elevate him to a position such as this and I indeed am flattered. Success in carrying out this obligation can be accomplished only with the help of everyone who takes pride in being a part of the Medical Association of Georgia.

After all, this is your organization and the Medical Association of Georgia is you. Having been a part of the so-called "establishment" for at least 20 years as delegate, vice-councilor, councilor, president-elect and now as your president, I believe we have a most democratic organization.

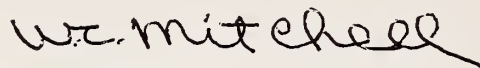
The delegates from your local society, meeting in annual session, make the rules and approve any actions of the past year. The Council, which is comprised of members from each congressional district society and from county medical societies having over 100 members, as well as your elected officers, is instructed by your House of Delegates as to how the business of running your State Association is to be conducted between annual sessions.

Council meets every three months to conduct the business of the Association as delegated by the House of Delegates. The Executive Committee of Council, responsible directly to Council, meets monthly to take care of the day-by-day business—this is done with the help of a most efficient staff of employees.

It is my intention, in the next 12 months, to try in a small way, through this media, to inform the rank and file of the membership of what's going on. So, read your *Journal* and your mail from Headquarters. Don't just sit on the sideline and belly ache and get your innards in an uproar. Join with us in the fight to save the private practice of medicine. Let your thoughts be known by writing, or coming to Council and Executive Committee meetings. These meetings are not closed to any member. True, the time and place of meetings is not set, but they are on a regular schedule; Council, once a quarter, and Executive Committee, once a month. Just call Headquarters' office and they will gladly inform you of the time and place. Visit with us—we just might find a spot for you on one of the committees, or a new committee could be created. The point I'm trying to make is that your organization is not a group of too many chiefs and not enough Indians—we want everybody to be a chief.

PRESIDENT'S LETTER / Continued

We have yet to have had a visitor to any of these meetings who has not been amazed at the amount of work done by your organization. This would be impossible without the most efficient and dedicated people we have at Headquarters. We want and need everyone to get involved and not to be a member of the silent majority. Speak up, loud and clear—we need you and your ideas. So until next month, You-all come,



W. C. Mitchell, M.D.
President, Medical Association of Georgia

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(2) Samuel N. Workman, M.D.
Chief of Clinical Services

(3) Charles W. Neville, Jr., M.D.
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DRUG THERAPY IN DISSECTING ANEURYSM

PAUL H. ROBINSON, M.D., *Atlanta*

ONE OF THE MOST SUCCESSFUL and gratifying recent innovations in cardiovascular therapeutics has been the use of anti-hypertensive therapy and beta adrenergic antagonists in acute dissecting aortic aneurysm. Dr. Myron Wheat has shown that the wave form of the pulse contour is probably responsible for continued dissection. A rapid upstroke in the pulse wave results in forces which tend to extend the dissecting hematoma. When the upstroke is slowed and the absolute level of pressure is reduced, the dissection potential is reduced, allowing time for cicatrization of the hematoma. The combination of direct anti-hypertensive drugs with beta blockade to reduce cardiac output and the velocity of aortic ejection, therefore, seems a logical approach to the management of most patients with acute dissection. The dramatic relief of pain when blood pressure is adequately lowered by drug therapy may also be very helpful in confirming the diagnosis of dissection.

The acute mortality in a series of patients with all types of aortic dissection managed on drug therapy at Columbia University and the University of Florida was 14 per cent. Prior to the institution of drug therapy the surgical mortality in all types of aortic dissection was approximately 40 per cent. Although 25 per cent of the drug treated patients in this study required late surgery for saccular aneurysm or significant aortic regurgitation, 84 per cent were alive at one year, 70 per cent at two, and 62 per cent at three years. During the follow-up period, nearly half of the patients died of causes unrelated to the dissecting aneurysm or its therapy.

Trimethaphan (Arfonad), 1-2 mg/ml at an intravenous rate sufficient to lower the systolic pressure to 100-120 mmHg is recommended for an immediate anti-hypertensive effect. During acute therapy the head of the patient's bed should be elevated on six-inch blocks. Since trimethaphan tachyphalaxis develops within 24 to 48 hours, the concomitant use of reserpine and propranolol is necessary. During the acute phase, 1-2 mg of reserpine every six hours may be required. Propranolol can be given intravenously or intramuscularly in a dose of 1 mg every 4-6 hours, but the patient's clinical status is usually so improved by blood pressure reduction that the oral use of propranolol, 5-10 mg every six hours is satisfactory. When these drugs are not available or tolerated other anti-hypertensive agents including methyldopa, guanethadine or one of the chlorthiazides can be used. During the acute phase of therapy, the urinary output must be maintained above 20 to 25 cc per hour. To maintain adequate urine flow it may be necessary to allow the systolic blood pressure to remain at a somewhat higher level. The maintenance of appropriate blood pressure levels may require constant physician attendance during the early period of regulation. Daily chest x-rays should be obtained to assess mediastinal size or the presence of pleural effusion and to determine whether a saccular aneurysm has developed. The latter requires surgical intervention. Acute intervention is also indicated for: 1) aortic regurgitation of sufficient magnitude to produce uncontrollable congestive heart failure; 2) compromise of a major artery where local surgery will relieve the obstruction; 3) blood pressure or pain uncontrolled within the first 4-6 hours; 4) impending rupture or leak; and 5) evidence of continued extension or enlargement of the aneurysm despite adequate medical therapy.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Following the acute phase, anti-hypertensive therapy should be continued as needed to maintain the systolic pressure at 100 to 120 mmHg in the erect position. Normotensive patients with dissection due to Marfan's syndrome or medial cystic necrosis and those with idiopathic dissection should continue on beta adrenergic blocking agents. Caution should be exercised in the use of all the therapeutic agents described. Trimethaphan can produce profound shock, ileus, bladder retention and visual disturbances. Guanethadine can result in significant postural hypotension, especially after exercise, and impotence and diarrhea. Reserpine may lead to severe depression and peptic ulcer disease. Aldomet occasionally causes headache, drowsiness, postural hypotension and diarrhea.

In conclusion, immediate institution of drug therapy is indicated for patients with acute aortic dissection unless systemic hypotension, acute myocardial infarction with normal or low pressure, or extensive cerebral damage is present. The indications for acute surgical intervention have been outlined. The selection of drug-treated patients for elective surgery at a later date must be based on the anatomical type of dissection, as determined by aortography, or the presence of late complications.

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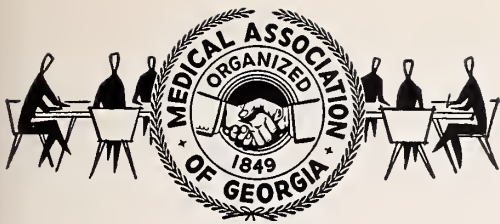
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THE ASSOCIATION

NEW MEMBERS

Adler, James S. Active—PD—Georgia Medical	St. Joseph's Hospital Savannah, Georgia 31401	Horton, Marley G., Jr. Active—GP—Georgia Medical	Candler General Hospital Savannah, Georgia 31405
Beeson, Charles W., II Active—C—Georgia Medi- cal	P. O. Box 6688, Station C Savannah, Georgia 31405	Kraatz, Robert W. Active—Path—Muscogee	Doctors Building Columbus, Georgia 31901
Berens, Sanford V. Active—R—Georgia Medi- cal	5223 Paulsen Street Savannah, Georgia 31405	Martynski, Stanislaw Active—PD—Walker-Ca- toosa-Dade	Hutcheson Memorial Hospital Fort Oglethorpe, Georgia 30742
Berg, Edward W. Active—OR—Richmond	Medical College of Geor- gia Augusta, Georgia 30902	Murphy, Harvey J. Active—SU—Georgia Medical	1 Medical Arts Center Savannah, Georgia 31405
Bradbury, Robert G. Active—R—Georgia Medi- cal	311 E. Hall Street Savannah, Georgia 31401	Neville, Rufus L., Jr. Active—U—Georgia Medi- cal	2515 Habersham Street Savannah, Georgia 31401
Cannon, Clifton L., Jr. Active—NS—Georgia Medical	22 Medical Arts Center Savannah, Georgia 31405	Oscar, Alvin D. Associate—OTO—Mus- cogee	Martin Army Hospital Fort Benning, Georgia 31905
Durisch, Lawrence L. Active—OTO—Hall	430 Washington Ave., N. E. Gainesville, Georgia 30501	Ravenet, Louis Active—P—Georgia Medi- cal	P. O. Box 13396 Savannah, Georgia 31406
Edwards, A. Joseph, Jr. Active—OBG—Georgia Medical	118 E. 35th Street Savannah, Georgia 31401	Rizo, Miguel A. Active—P—Whitfield	1217 Memorial Drive Dalton, Georgia 30720
Fernandez, Andres R. Active—Path—Baldwin	Central State Hospital Milledgeville, Georgia 31062	Waller, James T. Active—I—Georgia Medi- cal	P. O. Box 6688, Station C Savannah, Georgia 31405
Fernandez, Antonio Active—OR—Bibb	870 High Street Macon, Georgia 31201	White, Jess A. Active—OBG—Whitfield	P. O. Box 989 Dalton, Georgia 30720
Fillingim, John M. Active—GP—Georgia Medical	449 Abercorn Street Savannah, Georgia 31401	Wright, Donald A. Active—I—Georgia Medi- cal	2203 Abercorn Street Savannah, Georgia 31401
Galloway, George W., Jr. Active—GP—Cobb	Kennestone Hospital Marietta, Georgia 30060	Yager, Howard S. DE-4—PH—Fulton	50 Seventh Street, N. E. Atlanta, Georgia 30323
Garcia, J. Bernardo Active—Anes—Baldwin	Central State Hospital Milledgeville, Georgia 31061		
Garland, John W., III Active—P—Hall	700 S. Enota Drive Gainesville, Georgia 30501		
Gray, Samuel C. Active—SU—DeKalb	755 Columbia Drive Decatur, Georgia 30030		
Hetherington, Thomas A. Active—R—Georgia Medical	311 E. Hall Street Savannah, Georgia 31401		

PERSONALS

First District

John Mooney was the keynote speaker at a District Assembly on Drug Concerns in Valdosta in March. His address was titled, "At the End of the Rope."

Second District

Robert T. Morgan and family was honored as "Family of the Year" by the Sylvester Junior Woman's Club in March.

ASSOCIATION / Continued

Third District

George L. Epps was named a Fellow of the American College of Radiology in March.

Jose C. Serrato, Jr., has been appointed a National Advisor to the SAMA Standing Committee on International Health.

Fourth District

Ralph A. Tillman was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting, May 3-6, in San Francisco.

Fifth District

George H. Franck was named to the Board of Directors of the Industrial Medical Association at that organization's 56th annual meeting, April 19-22, in Atlanta.

John Rhodes Haverty has been appointed to the National Advisory Committee to the National Commission on Nursing and Nursing Education.

Bruce Logue was guest lecturer in April at the postgraduate course on Recent Advances in Cardiology, sponsored by the American College of Physicians and the Mount Sinai School of Medicine, New York City.

Alfred Messer spoke on "Physicians' Stress in the Practice of Medicine" before the Virginia Academy of General Practice in March, at Hot Springs, Virginia.

Three Atlanta physicians have been granted Fellowships in the American College of Cardiology. They are **Donald O. Nutter**, **Mark E. Silverman**, and **Nanette K. Wenger**.

Lamar B. Peacock was voted President-Elect of the American College of Allergists at the annual meeting of the College in San Francisco, March 29-April 1.

Sixth District

Lamar King was appointed to the Spalding County Hospital Authority in March.

Seventh District

Mark Gould has been named "Man of the Year" by the Georgia Psychiatric Association.

Richard L. Hammonds was elected to the board of directors of the Cobb County Bank in March.

John D. Knox, Jr., and **Frank W. McKinnon** were inducted as Fellows of the American Academy of Orthopaedic Surgeons at the group's annual meeting in San Francisco.

Eighth District

Bert H. Malone was honored posthumously by the American College of Radiology in March. The College named Dr. Malone a Fellow in their association.

Ninth District

Samuel O. Poole was named a Fellow of the American College of Cardiology in March.

A. G. Singer spoke on the duties of a medical ex-

aminer at the March meeting of the Toccoa Kiwanis Club.

Tenth District

Glen E. Garrison has been named a Fellow of the American College of Cardiology.

DEATHS

Trammell Starr, Sr.

Trammell Starr, Sr., died March 12 in Hamilton Memorial Hospital, Dalton. He was in his 50th year of practice.

A native of Calhoun, Dr. Starr was graduated in 1908 from Emory University. He studied medicine at Johns Hopkins University, graduating in 1912, and interned at City Hospital at Bay View, Maryland. He took his residency in surgery at Church Home and Infirmary of the City of Baltimore, doing postgraduate work in New York, New Orleans, and Mayo Clinic.

He served as a Lieutenant with the U. S. Medical Corps in World War I, returning to Dalton in 1919.

Dr. Starr was a member of the American Medical Association, the Medical Association of Georgia, the Whitfield-Murray County Medical Society and the First United Methodist Church of Dalton, where he served on the Board of Trustees. He was also the official surgeon for both the Southern and the L.&N. Railroads.

Charles Harold Watson

Charles Harold Watson died April 2 at University Hospital, Augusta, following an extended illness. He was 44.

A graduate of Emanuel County Institute, he attended Emory at Oxford and was graduated from the University of Georgia. He received his M.D. degree from the Medical College of Georgia in 1952 and interned at Duke Hospital, taking his residency in pediatrics at the Medical College of Georgia. He also had a one-year fellowship in pediatrics cardiology at the Medical College.

Dr. Watson was a member of the American Medical Association, the Medical Association of Georgia, the Richmond County Medical Society, the Georgia Pediatrics Society and the Southern Medical Association. He was also a member of Phi Rho Sigma medical fraternity and Kappa Alpha social fraternity.

A veteran of World War II, Dr. Watson was a former member of the board of the Augusta Speech and Hearing Center, a past president of the Journal Club of Augusta, and was a member of Covenant Presbyterian Church and the Augusta Country Club.

He is survived by his widow, the former Franceys Simmons; a daughter, Miss Sandye Watson of Houston, Tex.; two sons, **Charles Harold Watson, Jr.**, and **Mark Kennedy Watson**, both of Augusta; his mother and two brothers, **Luther L. Watson** of Twin City and **P. Holmes Watson** of Memphis, Tenn.

THE MONTH IN WASHINGTON

American Medical Association spokesmen urged that the AMA Medcredit national health insurance program be adopted as the best way to assure the nation's poor access to quality medical care and to free families with moderate incomes from the fear of bankruptcy resulting from a long, costly illness.

Dr. Max H. Parrott, chairman of the Board of Trustees, and Dr. Russell B. Roth, speaker of the House of Delegates, represented the AMA before the Senate Health subcommittee at one of its hearings on national health insurance and major health care problems facing the nation.

They estimated the first year cost of Medcredit at \$14.5 billion, much less than some proposals before Congress that would have the federal government virtually take over the nation's health care delivery.

The Medcredit legislation (H.R. 4960 and S. 987) has been introduced in Congress with 131 Democrats and Republican members as sponsors.

Dr. Roth said that Medcredit, "without disturbing the present medicare program for the elderly . . . makes available to everyone under 65 a private program of comprehensive medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident."

Warning

Dr. Parrott warned against legislating revolutionary changes in health care delivery. He urged that innovations be tried on an experimental scale instead.

"The American medical-health care system needs something more than a poultice, but something less than a burial," he said.

"The AMA believes we can bring about needed improvements without gambling on a whole new medical-health care system whose effects and effectiveness are unpredictable. . . . The American doctor is sincerely concerned over the prospect of any sudden, single, massive unevaluated experiment which would cast all 200 million Americans in the role of the guinea pig."

Problem Response

Dr. Parrott also testified that many health problems would respond best to programs that are not purely medical.

"Our fat standard of living creates health problems," he said. "We ride in cars when we should be on a bicycle or on foot. We overeat. We overdrink. We smoke cigarettes. This affluent life style relates directly to the accident rate, the principal killer up to middle age, and to heart diseases, the principal killer after middle age."

Speaking as a practicing obstetrician, Dr. Parrott pointed out that infant mortality rates in this country are not entirely a medical problem. They are linked closely to malnutrition and other conditions of poverty, particularly in urban ghettos, he said.

"If we could create a broad program that would bring dignity into the lives of people in our slums, if we could create a world every mother wanted to bring her child into, that would do more to improve infant mortality than a hundred Mayo clinics," he said.

Program Need

The chairman of the AMA's Council on Rural Health told the Senate Health Subcommittee that a variety of new health programs are needed to solve the problems of health care in rural communities.

The AMA spokesman, Leopold J. Snyder, M.D., Fresno, Cal., said some of the new programs already are being tried.

"Experience indicates that no one approach will solve the health needs of every community. Any attempt to find single causes for these health problems, or simple solutions to them, is bound to result in total frustration.

"While medical solutions are being sought, we believe that the root causes to these problems—largely socio-economic in character—should be identified and resolved."

No Access to Care

Dr. Snyder explained to the subcommittee that while large segments of people in rural communities have access to quality health care, there are still large segments which do not.

"In some instances," he said, "these people live in remote localities, far from the nearest health center. In other cases, their lack of adequate health service can be attributed to reasons of economics, immobility, cultural attitudes, and a host of other causes.

"Whatever the reason, the American Medical Association believes every person should have access to ade-

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WASHINGTON / Continued

quate health care, whether he lives in a city, or some remote rural region, regardless of his economic circumstances.

"Doctors are aware of the need for better health care in rural communities. Together with other groups and organizations, we are actively developing new approaches to the problems."

New Programs

Among the new programs under study by the AMA, he said, are:

—In Seattle, the University of Washington is providing former medical corpsmen with a three-month refresher course on civilian medical procedures. Upon completion of the course, these former medics are sent to physicians across the state, who have agreed to act as their preceptors, and to employ them after 12 months of on-the-job experience. Some of these men are already on the job, mostly in rural communities. This Medex Program, as it is called, is supported by the Washington State Medical Association and its Education and Research Foundation, as well as the AMA's Council on Rural Health.

—In Lawrence County, Ala., another project also involves the services of former medical corpsmen. In this Appalachian area, there are only six physicians to serve a population of 30,000. Basically, the project has two modes of patient contact—a family care unit and "out-reach" teams. The out-reach teams introduce families to the community health service personnel, who can then begin the history-taking process and refer the family to the family care unit.

—In southern Monterey County, Cal., a small population is increased to 23,000 by a seasonal influx of migrant farm workers. A group of 10 physicians and 80 supporting ancillary staff members have undertaken to provide medical care to all eligible residents, including migrant farm workers. Patients are cared for in the same facilities, by the same medical staff that serves the self-sustaining members of the community. Transportation—including a van, equipped for wheelchair patients—serves the entire project area. Grantee for the project is the Monterey County Medical Society with funds from the Office of Economic Opportunity.

—Another significant approach may soon be attempted in the wilderness of southwestern New Mexico. This is a 50,000 square mile region of high mountain ranges and portions of the Chihuahua and Sonora Deserts. Some 95,000 inhabitants of the region are served by only three physicians.

The program here calls for a central health center and a series of remote health stations. The stations will be staffed by persons trained in health care, but not as highly trained as a physician. They will be equipped with sensors, similar to those used by the National Aeronautics and Space Administration to monitor the health of the astronauts. Thus, a patient visiting one of the remote health stations will have attached to himself the electronic sensors, which will transmit heartbeat, respiration, blood pressure and other vital data to the computer-controlled center, where a physician would monitor the symptoms and advise the allied health staffer by radio.

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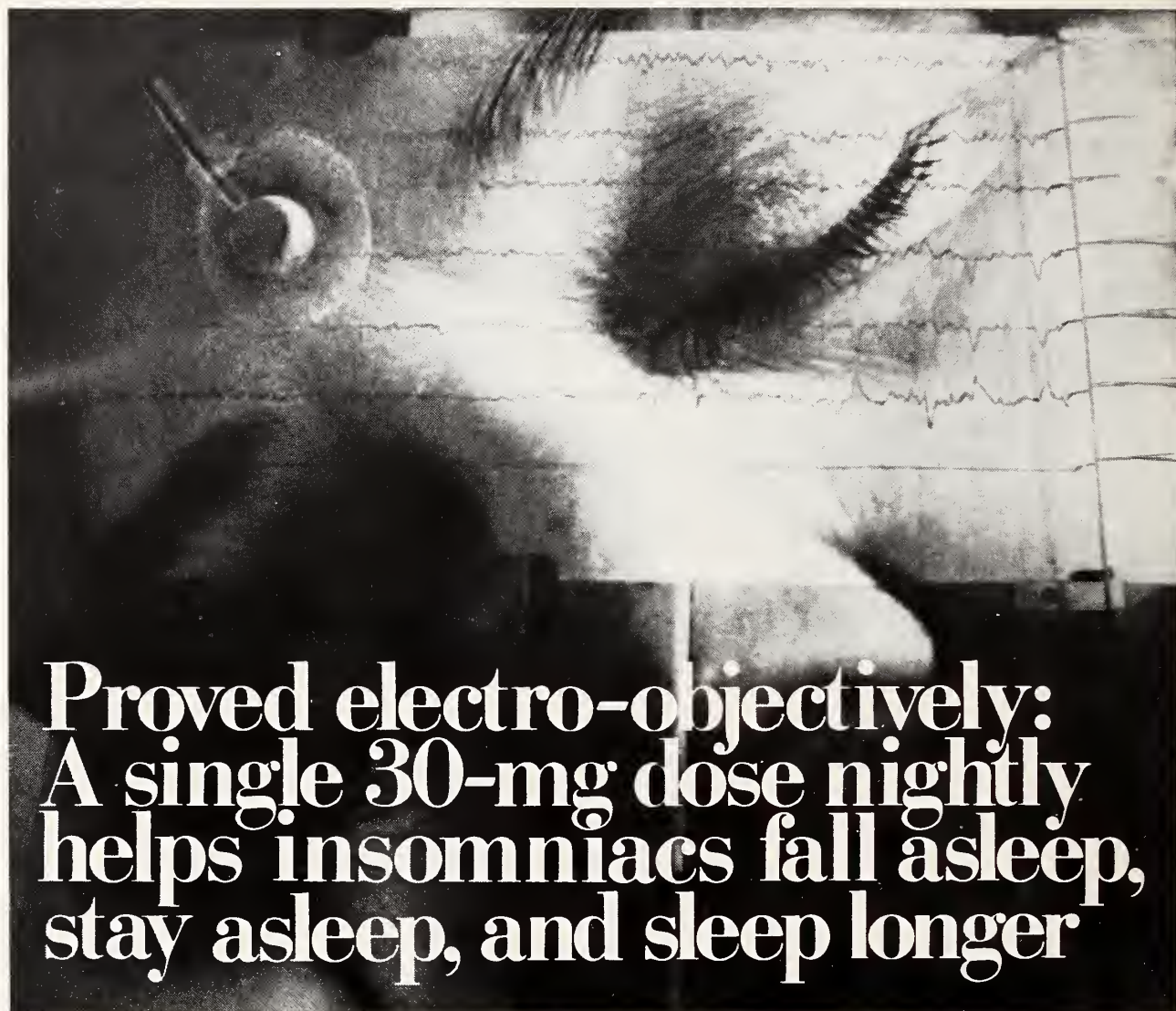
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Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,¹ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

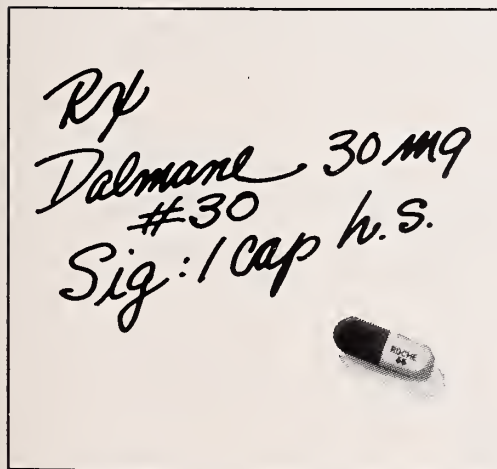
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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(flurazepam hydrochloride)

Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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Cover

Designed by Mr. Robert Hamill, Atlanta.

MAG General Session (First Session)

117th Annual Session of the Medical Association of Georgia

Friday, May 14, 1971

THE FIRST GENERAL SESSION of the 117th Annual Session of the Medical Association of Georgia was called to order by President Franklin G. Eldridge, M.D., Valdosta, at 9:00 a.m., in the North and Center Ballrooms of the Marriott Motor Hotel, Atlanta, Ga., on May 14, 1971.

Dr. Eldridge welcomed those members present and stated that while enjoying the splendid hospitality of Atlanta and the Fulton County Medical Society, it was most appropriate that we count our blessings and give thanks together. Dr. Eldridge then called on the Rev. John E. Burciaga, pastor of the Northwest Unitarian Church of Roswell, Ga., who led the General Session in the invocation.

Dr. Eldridge then presided as the Third U.S. Army Color Guard from Fort McPherson, Ga., presented the colors, and the national anthem was played as recorded by the Third U.S. Army Band under the baton of Conductor C. A. Martin.

President Eldridge then recognized the President of the Fulton County Medical Society, Dr. Robert E. Wells, Atlanta, who extended words of welcome to the Association from the host society.

President Eldridge next recognized Mr. Roland Maxwell, of Atlanta, President of the Atlanta Chamber of Commerce, who reviewed the development of medical care in Atlanta and Georgia and expressed the greetings of the Atlanta Chamber of Commerce to the Association.

President Eldridge then introduced Miss Penny Bank, who spoke to the General Session on the many interesting places to see in Underground Atlanta.

President Eldridge then called on Dr. S. William Clark, Waycross, Chairman of the Advisory Committee to the Woman's Auxiliary, to escort Mrs. George W. Statham, Atlanta, President-Elect of the

Woman's Auxiliary to the Medical Association of Georgia, to the podium, where she delivered a report on the activities of the MAG Auxiliary in behalf of Mrs. Charles R. Smith, Columbus, President of the MAG Auxiliary. Mrs. Statham prefaced her remarks by introducing a special guest of the MAG Auxiliary, Mrs. Amos Johnson, of Garland, N.C., Southeastern Region Vice President of the Woman's Auxiliary to the American Medical Association, who was attending the MAG Annual Session as a guest and program participant during the Annual Session of the Woman's Auxiliary to the Medical Association of Georgia.

President Eldridge then announced that two special guests would be extended the privilege of the floor for brief remarks to the Association. He ex-



Mrs. George W. Statham, Atlanta, delivers a report on the Woman's Auxiliary, to the MAG House of Delegates.

plained that MAG had been following the steady progress of the two student AMA Chapters in Georgia as well as advances in student concerns and activity nationally, and acknowledged that the President of two student AMA Chapters were providing leadership to those activities in Georgia. Dr. Eldridge first introduced Mr. John D. Slade, President of the SAMA Chapter at Emory University, who delivered a message to the Association. Dr. Eldridge then recognized Mr. Paul C. Atwater, President of the SAMA Chapter at the Medical College of Georgia, and announced to the audience that Mr. Atwater was the son of MAG Treasurer, Dr. John S. Atwater, of Atlanta. Mr. Atwater also spoke to the Association.

President Eldridge then called on President-Elect William Claude Mitchell, M.D., of Smyrna, who presented his Incoming President's Address to the Association membership on "The Challenge to MAG."

President-Elect's Address

W. C. MITCHELL, M.D., *Smyrna*

Mr. President, members of the Medical Association of Georgia, members of the Medical Auxiliary, and Distinguished Guests:

This is indeed a high honor that has been bestowed upon me, and I want you to know that I feel most humble and deeply appreciative to have been chosen to serve as President during the coming year. Little did I realize, when I first became a member of this organization 38 years ago, during the presidency of Dr. Charles Richardson, that I would be standing here today. Following presidents of the caliber of Tex Eldridge, Kirk Train, Charlie Andrews, John Mauldin, Walter Brown, George Alexander, J. G. McDaniel, and all those back to Dr. Charlie Richardson's time, causes me to feel a little apprehensive of being able to carry on in the image that they have so nobly carved into our organization. Someone, knowing the job that lies ahead of me, asked if I had lost any sleep just thinking about it. My reply to this was: "No, I was sleeping like a baby—waking up every three hours screaming out loud."

I know I could never fill the giant shoes of my predecessors, but being the giants that they were, I'm going to try standing on their good strong shoulders and give it my very best.

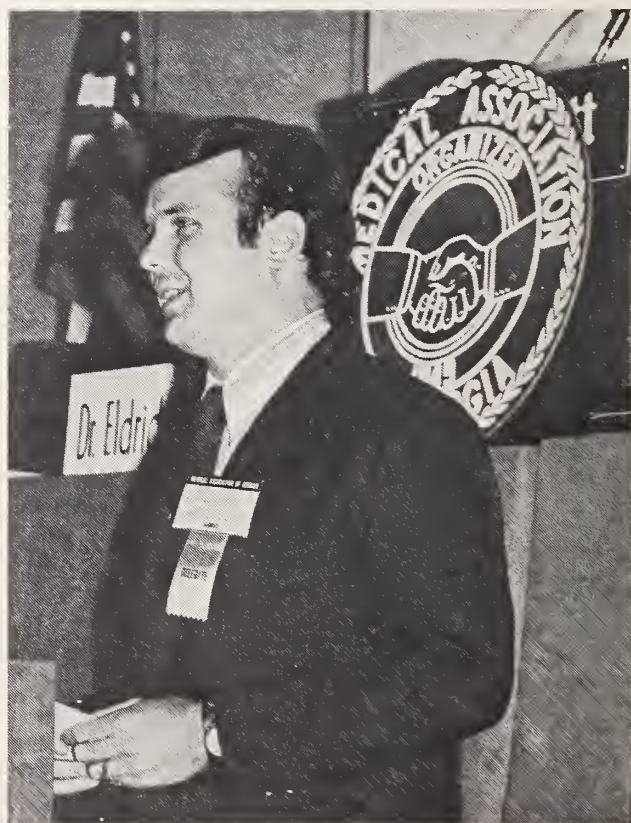
When I first began practice, nearly 40 years ago, it was necessary for Doctors to make house calls. Everyone didn't have an automobile—there were not many ambulances, and very few telephones. The belief at that time was widely held that a sick person shouldn't get out from under the quilt. Doctors in those days were comforting, reassuring, and unhurried—and for good reason. Comfort and reassurance were about all we had to offer. The sulfas came along in the late thirties, followed by penicillin in the forties, and then came the whole range of chemotherapeutic aids and antibiotics. Today Doctors have at their command the tools of electronics, biochemistry, nuclear physics, and the mass array of drugs coming from continuing pharmaceutical research. The fact that we can do so much

more and see so many more patients is in itself frustrating both to the patient and to the Doctor, and with this scientific revolution which began gathering momentum some 20 years ago, there came an ever-widening gap between the public and the health care teams.

Today, medicine is being challenged as never before, with so many changes taking place, we have not only the problem of keeping up with the new, but trying to sort out the good in both the old and the new. These changes do affect us all, and how we handle them will determine whether we end the decade of the seventies with a vibrant living organization, or with something that will exist only in our memories. We will have to excel in planning, decision-making, in formulating and executing the whole strategy or game plan. We will need insight into the nature and mix of the political, economic, and social forces of our society. These are all moving and changing forces and they are not susceptible to any fixed formula or to any preconceived solutions. Our judgments must be peripheral, with a vision as steady and sweeping as the scope of a radar screen constantly registering the forces and trends about us.

Our future depends on how well we keep up with all these changes and tailor our services to be more effective. Thinking first, last and always of what's best for our patients—always keeping in mind—we are what we are—as individuals and as an Association, in order to serve the people who come to us with need. And we want these services to be the very best—of the highest quality—and provided at the most reasonable cost possible.

In order to do a better job, we should be freed of restrictive regulations that do not affect the safety and



Mr. Paul C. Atwater, President of the SAMA Chapter, Medical College of Georgia.

health care of our patients. Government constraints that distort the normal workings only impair the ability of the physician to function properly and are of no value to either the patient or his Doctor. Regulatory decisions, once made and implemented, appear to be impervious to change even when they have become obsolete by their own standards.

The communications gap, as we all know, is real and large. It could be because we spend too much time telling ourselves what we want to hear. This results in a satisfying sense of agreement among ourselves, but very little communicating to others of the principles and values that we agree on. Our legislators, for example, have as good grounds for complaining about our grasp of their business as we have of complaining about their grasp of ours. We need to develop an informed, positive approach to the political process. We need to understand and appreciate the problems that health care issues present to those who bear the burdens of legislation.

We are heading for more dynamic exciting days. We neither expect, nor do we want, a slowing of the pace of change or a lowering of the level of the challenge that change has brought about. But we must ask for a fair opportunity to meet the challenge in a way that is at least a little consistent with the traditions of a free practice of medicine and in a free society that has confidence in our capacity to make correct and responsible decisions—and with the right to be judged accordingly.

RECOMMENDATIONS

With these thoughts in mind, it is my recommendation:

- (1) That we strengthen our public relations both in means and methods.
- (2) That we give all support possible to GaMPAC and AMPAC.
- (3) That we offer our services and help to our political community, in an effort to keep them from getting so frustrated in health care matters. We know there are gaps to close and bridges to cross. We would like to help keep some of them from running off these bridges.
- (4) We should get more involved in the socio-economic field. In matters of drug abuse, alcoholism, mental health, aging, pollution, education, public health, and civic club endeavors, to mention just a few.
- (5) Continue to support and solicit the help of our women's auxiliary, for we know that generally speaking, our ladies are "Generally speaking" for us.
- (6) Strengthen and get more members familiar with the Foundation program for peer review.
- (7) We must give thought and make plans for a change in our dues structure which is the lowest in the nation (\$40.00), compared to Alaska's \$200.00 per year which is the highest. We should be somewhere in between these two extremes. One of the sub-rosa practitioner groups that attempts to be part of the health care program, and a group that costs us the most in time, energy, and money in fighting their bills in the legislature, has dues of \$500.00 per annum, and this is supplemented with frequent assessments as the need arises. It has only been through the efforts of a frugal house, the wise planning of our budget committee, the foresight of those who helped in getting the several

government programs housed in our building, and the untiring efforts of those who work on our multitude of committees contributing their time and travel costs freely without any thought of remuneration, that we have been able to do the many things we have done at so low a cost to the membership.

Many things could happen to change all these favorable situations, and it is high time we took steps to insure ourselves of being able to finance needed programs in the foreseeable future.

(8) Due to the economics of the times, and the over-utilization of the profession, it has been easy for charlatans and perpetrators of frauds to take advantage of a public that is seeking medical help. There are, I am sorry to say, a very, very small number of these who are members of our organization, and who use their membership as a shield to give legality and respectability to their nefarious operations. These were accepted as members because they had the necessary qualifications and recommendations. Once members, there is very little we can do to purge them from our rolls. Considering the old cliché of the one rotten apple in a barrel, we should find some means in either our own constitution or by state legislation to correct this situation.

(9) The paramedical groups need our continuous support and in this time of shortages even more so. A new group, the Medex (or physician's assistants) are on the verge of coming into their own. We feel there is a definite need for this type of help. It will be most welcome, but careful plans for training and supervision must be formulated in order for this to add strength to the overall health care program. We must never use the excuse of pressure and unavailability to allow ourselves to surrender to mediocrity.

With the efficient headquarters staff, the dedication of the House of Delegates, the members of Council, the hard working committees, and believing the membership as a whole stands ready to pitch in and help, and if the good Lord will give us the strength to accept that which we cannot change, and the needed help to change that which is not acceptable, I know the upcoming year will be a success and the Medical Association of Georgia will meet the challenge.

President Eldridge thanked Dr. Mitchell for his thought-provoking message and made several announcements, including the arrangements for the Medical Mile, which was to be run indoors in 1971 for the first time, on the large indoor track at the Downtown Atlanta YMCA. Dr. Eldridge also announced that closed circuit television was being provided for the entertainment and education of those attending the 117th Annual Session with programs to be aired on the hotel's channel 4 between 5:00 p.m. and 1:00 a.m.

At this point President Eldridge announced that the MAG General Session would be recessed and that the meeting would be turned over to Dr. Harrison L. Rogers, Atlanta, Speaker of the MAG House of Delegates, to preside at the First Session of the MAG House of Delegates meeting.

First Session, House of Delegates

Friday, May 14, 1971

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., M.D., Atlanta, at 10:05 a.m., in the North and Center Ballrooms, Marriott Motor Hotel, Atlanta, Ga., in conjunction with the 117th Annual Session of the Medical Association of Georgia. Speaker Rogers extended a warm welcome to the Delegates in attendance and briefly reviewed the schedule of the transaction of business by the House of Delegates during its two 1971 Sessions, including the Reference Committee system and their schedules for meetings.

Speaker Rogers then called for a report of the Delegates in attendance. Dr. Bill Purcell, of Calhoun, Chairman of the House of Delegates Credentials Committee, reported that there were 130 Delegates present and registered, representing 51 component societies, and that there was a quorum of more than 40 members present and accounted for. A complete report made by the Credentials Committee on the attendance at the First Session of the House of Delegates is as follows:

Attendance

In a compilation of attendance taken from the official roll, 51 county medical societies were presented by their duly elected Delegates or alternates. Of a total 170 authorized Delegates by their respective medical societies, the official roll showed 146 delegates present at this First Session.

ALTAMAHA: E. J. Virusky; BALDWIN: Samuel M. Goodrich; BEN HILL-IRWIN: Ralph D. Roberts; BIBB: Ferdinand V. Kay, A. L. Mayes, Jr., Jack F. Menendez, B. B. Sanders, G. C. Schlottman and Henry H. Tift; OGEECHEE RIVER: Charles Richardson; CARROLL-DOUGLAS-HARALSON: Phil C. Astin and J. Larry Boss; GEORGIA MEDICAL: Carson B. Burgstiner, J. P. Evans, J. Robert Logan, Joseph A. Mulherin, Dearing A. Nash, David E. Tanner and Alton F. Williams; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald L. Branyon, F. M. McElhannon and William Mulherin; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, Luther G. Fortson, James H. Manning, Robert D. May, Stephen C. May, Jr., Charles J. Rey and Donald R. Rooney; COLQUITT: Walter Harrison; COWETA: Robert J. Jarrell; DEKALB: Philip E. Christopher, John Heard, P. M. Jardina, William J. Rawls, Roger Rowell, George W. Statham, O. W. Stubbs, Knox Walker, Jr. and Charles B. Watkins; DOUGHERTY: J. Daniel Bateman, Charles Hollis, Jr. and Robert D. Waller;

EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: W. H. Lucas and Jack R. Meacham; ELBERT-FRANKLIN-HART: J. Weldon Williams, Jr.; FULTON: Earl L. Alderman, John S. Atwater, Tully T. Blalock, J. Norman Berry, James N. Brawner, III, Spencer Brewer, Jr., F. William Dowda, W. R. Edwards, Edwin C. Evans, Henry Finch, G. Lester Forbes, Joseph Girardeau, Irving L. Greenberg, Alton V. Hallum, Jr., L. Harvey Hamff, J. Harold Harrison, John Rhodes Haverty, William Huger, Jr., Fleming L. Jolley, James A. Kaufmann, W. D. Logan, J. G. McDaniel, William L. McDougall, William W. Moore, Jr., W. P. Nicholson, Edwin Pound, Jr., Harold S. Ramos, Albert A. Rayle, Jr., Harrison L. Rogers, Jr., John K. Schellack, Lee R. Shelton, Hugh Thompson, Charles E. Todd, L. N. Turk, J. Frank Walker, W. C. Waters, Robert E. Wells, Frank C. Wilson and Joseph S. Wilson; GLYNN: C. S. Britt; GORDON: Bill Purcell; HABERSHAM: Thomas N. Lumsden; HALL: Billy S. Hardman, John Reed and C. W. Whitworth; PEACH BELT: Carl L. Crawford and H. E. Weems; JACKSON-BANKS: E. W. Holloway, Jr.; LAURENS: W. M. Watkins; McDUFFIE: Thomas E. Averitt; MERIWETHER-HARRIS: William G. Chambless; MUSCOGEE: Henry H. Boyter, Bob Maughon, T. Jack McGee, Jack A. Raines and Luther J. Smith, II; OCONEE VALLEY: C. H. Dickens; OCMULGEE: William E. Coleman; POLK: Don Schmidt; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Clyde A. Burgamy, Preston D. Ellington, William A. Fuller, Ronald F. Galloway, Menard Ihnen, Julius T. Johnson, William Moretz, Stuart H. Prather, Henry D. Scoggins, Walter L. Sheppard and C. A. White, Jr.; SCREVEN: James C. Freeman; SOUTH GEORGIA: R. A. Acree, Charles A. Hodges, Jr. and Joe C. Stubbs; SPALDING: Alex P. Jones and James M. Skinner; STEPHENS: Irving D. Hellenga; SUMTER: Bon M. Durham; THOMAS-BROOKS-GRADY: Donald J. McKenzie and Frank R. Miller; TIFT: R. P. Wight, Jr.; TROUP: Charles T. Cowart and A. J. Nelson, III; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: M. K. Cureton; WARE: S. W. Clark and Floyd Davis; WAYNE: Ollie O. McGahee; WHITFIELD: Earl T. McGhee and James J. Oosterhoudt; WILKES: M. C. Adair; WORTH: H. G. Davis, Jr.; SAMA DELEGATE—EMORY: Salley S. Jesse; SAMA DELEGATE—MEDICAL COLLEGE OF GEORGIA: H. Stanley Guest.

Dr. Rogers thanked the Chairman of the Committee on Credentials and announced that the business of the House could proceed. He requested that only Delegates sit in the area reserved for MAG Delegates only, since the privilege of the floor was limited to members and ex-officio members of the House of Delegates, and that voting must, of necessity, be limited to duly elected Delegates identified by their special Delegates ribbon badges.

Speaker Rogers then introduced the Vice Speaker of the House of Delegates, Preston D. Ellington, M.D., of Augusta, and explained fully the methods of consideration of business to be brought before the House of Delegates.

Speaker Rogers then announced the appointment of the House of Delegates' Credentials Committee and the appointment of the House of Delegates' Tellers Committee as follows:

CREDENTIALS COMMITTEE: Bill Purcell, Calhoun, Chairman; L. J. Smith, Columbus and Edwin C. Pound, Atlanta.

TELLERS COMMITTEE: W. A. Fuller, Augusta, Chairman; John H. Reed, Gainesville and C. H. Dickens, Macon.

Speaker Rogers then appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: Rupert H. Bramblett, Cumming, Chairman; Jack A. Raines, Columbus, Vice Chairman; William Perrin Nicolson, III, Atlanta; Samuel M. Goodrich, Milledgeville; R. D. Roberts, Fitzgerald; John P. Heard, Decatur; staffed by Mr. Carl G. Bailey.

REFERENCE COMMITTEE B: Ollie O. McGahee, Jr., Jesup, Chairman; Henry H. Tift, Macon, Vice Chairman; Don Schmidt, Cedartown; Alton F. Williams, Savannah; H. H. Boyter, Columbus; W. C. Waters, Atlanta; staffed by Mr. James M. Moffett.

REFERENCE COMMITTEE C: Joe C. Stubbs, Valdosta, Chairman; Philip M. Jardino, Decatur, Vice Chairman; J. M. Byne, Jr., Waynesboro; Donald R. Rooney, Marietta; Hugh S. Thompson, East Point; J. L. Boss, Villa Rica; staffed by Mr. Adam R. Jablonowski.

REFERENCE COMMITTEE D: Ronald F. Galloway, Augusta, Chairman; Billy S. Hardman, Gainesville, Vice Chairman; J. W. Smith, Manchester; L. Newton Turk, Atlanta; Charles T. Cowart, LaGrange; S. William Clark, Waycross; staffed by Mrs. Catherine L. Wooten.

To expedite the adoption of the minutes of the 1970 Sessions of the House of Delegates in conjunction with the 116th Annual Session of the Medical Association of Georgia, convened on May 8 and 10, 1970, at the Aquarama, Jekyll Island, Ga., the Chair entertained a motion that the minutes, as published in the June, 1970, issue of the *Journal of the Medical Association of Georgia*, be approved. On motion duly made and seconded, it was voted that these minutes be so approved as published in their entirety in the June 1970 issue of the *JMAG*.

Speaker Rogers then announced that pursuant to an action of the 1970 House of Delegates allowing for the presence of a Delegate from each of Georgia's two Student American Medical Association Chapters, the House of Delegates was pleased to have present the duly elected Delegate from those two SAMA Chapters. Speaker Rogers then introduced Sally Jesse, Delegate from the SAMA Chapter

of Emory University, and Mr. Stan Guest, Delegate from the SAMA Chapter at the Medical College of Georgia.

Nominations

Speaker Rogers then called on the House to proceed with the nominations of Officers, AMA Delegates and Alternate Delegates to AMA, and requested that nominating speeches be limited to a maximum of two minutes and seconding speeches be limited to a maximum of one minute each. Speaker Rogers identified a nominations worksheet in each Delegate's Handbook for the recording of the names of nominees and then called for nominations from the floor for the Association's Officers, with the following nominations being made:

PRESIDENT-ELECT: F. William Dowda, Atlanta, nominated by John Kirk Train, Jr., Savannah, at the request of the Chairman of the Fulton County Medical Society delegation, Robert Wells; seconded by Remer Y. Clark, Cobb County Medical Society; M. A. Hubert, Crawford W. Long Medical Society; Joseph Stubbs, South Georgia Medical Society; Philip Jardina, DeKalb County Medical Society; Preston D. Ellington, Richmond County Medical Society; Braswell E. Collins, Bibb County Medical Society; James Kaufmann, Fulton County Medical Society; Dan Bateman, Dougherty County Medical Society.

There being no other nominations for the office of President-Elect, on motion duly made and seconded, the nominations were closed.

Speaker Rogers then reminded the Delegates that the Second Vice President automatically accedes to the office of First Vice President, thereby obviating the need to nominate a First Vice President. Speaker Rogers announced that the First Vice President for 1971-72 would be Henry D. Scoggins, of Augusta.

SECOND VICE PRESIDENT: Braswell E. Collins, of Macon, was nominated for the office of Second Vice President by Henry Tift, Bibb County Medical Society; seconded by John S. Atwater, Fulton County Medical Society; C. Emory Bohler, Council, and John Shellack, Fulton County Medical Society.

There being no further nominations for the office of Second Vice President, on motion duly made and seconded, the nominations were closed.

Speaker Rogers then reminded the House that the Speaker and Vice Speaker of the House of Delegates serve three-year terms beginning with the adjournment of the Second Session. Dr. Rogers then called for nominations for Speaker of the House to serve from May, 1971, to May, 1974, and asked Dr. Ellington to assume the Chair to receive the nominations for the office of Speaker.

SPEAKER OF THE HOUSE OF DELEGATES: Harrison L. Rogers, Jr., was nominated by J. Frank

Walker, Fulton County Medical Society; seconded by C. Emory Bohler, Council.

There being no other nominations for the office of Speaker of the House of Delegates, on motion duly made and seconded, the nominations were closed.

VICE SPEAKER: Preston D. Ellington, Augusta, was nominated for the office of Vice Speaker of the House of Delegates by Ronald Galloway, Augusta; seconded by C. Emory Bohler, Council, and Braswell Collins, Bibb County Medical Society.

There being no further nominations for the office of Vice Speaker of the House of Delegates, on motion duly made and seconded, the nominations were closed.

Speaker Rogers then noted that in accordance with MAG Bylaws, as revised in 1966, under Chapter V, Section 2, Nomination, it is stated that if a District Society or a component County Medical Society is entitled to direct representation by one or more Councilors and Vice Councilors, the Secretary of the MAG must receive no later than 15 days before the Annual Session, written notice of the election of Councilors and Vice Councilors, that these Councilors and Vice Councilors may be considered by the Association as duly elected, and nominations from the floor are only to be accepted in the absence of such notification of election to the Secretary of the MAG 15 days in advance of an Annual Session.

Speaker Rogers stated that he was happy to report that the District and County Medical Societies whose Councilors' and Vice Councilors' terms of office had expired had duly notified MAG of their elections and no nominations from the floor were then in order.

Dr. Rogers then read the notification of these elections as received by the MAG from the Secretary of the respective District and County Medical Societies as follows:

Sixth District Councilor—Norman P. Gardner, Thomaston, 1974

Sixth District Vice Councilor—W. E. Barron, Jr., Newnan, 1974

Seventh District Councilor—David A. Wells, Dalton, 1974

Seventh District Vice Councilor—Don Schmidt, Cedartown, 1974

Eighth District Councilor—Robert E. Perry, Brunswick, 1974

Eighth District Vice Councilor—Joe C. Stubbs, Valdosta, 1974

Cobb County Councilor—Remer Y. Clark, Marietta, 1972

Cobb County Vice Councilor—Charles R. Underwood, Marietta, 1972

DeKalb County Councilor—M. Freeman Simmons, Decatur, 1972

DeKalb County Vice Councilor—L. C. Buchanan, Decatur, 1972

Fulton County Councilor—John T. Godwin, Atlanta, 1974

Fulton County Vice Councilor—J. Norman Berry, Sandy Springs, 1974

Muscogee County Councilor—Jack A. Raines, Columbus, 1974

Muscogee County Vice Councilor—Louis A. Hazouri, Columbus, 1974

Speaker Rogers then stated that the MAG had been notified by the President of the First District that on resignation of J. Roy Rowland, Jr., as First District Vice Councilor, Albert M. Deal, Statesboro, was elected Vice Councilor with term expiring 1973.

AMA Delegates

Speaker Rogers then called for nominations for MAG Delegates to the American Medical Association and stated that he would identify the elective posts by announcing the name of the incumbent in office and also giving the term of office.

AMA Delegate for the office held by J. W. Chambers of LaGrange, the term beginning January 1, 1972, and expiring December 31, 1973—J. W. Chambers, LaGrange, nominated by Charles Cowart, Troup County Medical Society; seconded by Henry Tift, Bibb County Medical Society, and George Alexander, Bibb County Medical Society.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Delegate for the office held by John S. Atwater, of Atlanta, the term beginning January 1, 1972, and expiring December 31, 1973—John S. Atwater, Atlanta, nominated by F. William Dowda, Fulton County Medical Society; seconded by Ronald Galloway, Richmond County Medical Society; Joe T. Christmas, Flint County Medical Society; and Robert Wells, Fulton County Medical Society.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Alternate Delegate for the office held by Neal F. Yeomans, Waycross, the term to run January 1, 1972, and expiring December 31, 1973—F. G. Eldridge, Valdosta, nominated by Neal F. Yeomans after announcing that he would not be a candidate for re-election; seconded by J. Frank Walker, Fulton County Medical Society; and J. W. Chambers, Troup County Medical Society.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Alternate Delegate for the office held by Henry S. Jennings, Gainesville, the term beginning January 1, 1972, and expiring December 31, 1973

—Henry S. Jennings, nominated by W. S. Hardman, Hall County Medical Society; seconded by Charles Cowart, Troup County Medical Society; Charles Hollis, Dougherty County Medical Society; and J. Weldon Williams, Elbert-Franklin-Hart County Medical Society.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

Speaker Rogers then announced that the election of Officers would take place at the Second Session of the House of Delegates, to be convened on Sunday, May 16.

General Practitioner of the Year Award

Speaker Rogers announced that pursuant to an action of the 1970 House of Delegates, the General Practitioner of the Year Award recipient is selected by the Georgia Academy of General Practice. Dr. Rogers announced that it was a tradition of the MAG to call on the President of the Georgia Academy of General Practice to present this Award to his fellow practitioner in behalf of the Medical Association of Georgia. Therefore, Dr. Rogers called for Dr. R. D. Walter, Calhoun, President of the Georgia Academy of General Practice, to make the presentation of the General Practitioner of the Year Award.

Dr. Walter stated that on the basis of "It takes one to know one," the Georgia Academy of General Practice accepted with pleasure its assignment. He announced that the recipient of the Award this year had a long history of good medical practice in Georgia. He is a Past President of the Georgia Academy of General Practice, a physician with years of distinguished service on numerous committees of the Medical Association of Georgia, and a more than casual interest in the Georgia Medical Political Action Committee. Dr. Walter then announced that the 1971 recipient of the General Practitioner of the Year Award was Dr. T. A. Sappington, of Thomas-ton, and asked Dr. Sappington to come forward and receive his award.

Annual Report

Speaker Rogers then called for the Annual Reports of Officers, Council, Councilors, Vice Councilors, AMA Delegates, Association Committees, and other reports to be introduced at this Session, which are listed below with the appropriate Reference Committee indicated for those reports which were referred. The full report, the action of appropriate Reference Committees, and the House of Delegates action on each is listed under the proceedings of the Second Session of the House of Delegates on those reports and resolutions which were referred to Reference Committees. (See pages 197 to 235.)

OFFICERS

President—Not Referred
President-Elect—Not Referred
First Vice President—Not Referred
Second Vice President—Not Referred
Secretary—Reference Committee B
Treasurer—Reference Committee B
Speaker of the House—Reference Committee A
Vice Speaker of the House—Reference Committee D
AMA Alternate Delegate (Dowda)—Reference Committee A

COUNCILORS AND VICE COUNCILORS

Chairman of Council—Not Referred
First District Councilor—Not Referred
Second District Councilor—Not Referred
Third District Councilor—Not Referred
Sixth District Councilor—Not Referred
Seventh District Vice Councilor—Not Referred
Eighth District Councilor—Not Referred
Ninth District Councilor—Not Referred
Tenth District Councilor—Not Referred
Bibb County Medical Society Councilor—Not Referred
Cobb County Medical Society Councilor—Reference Committee A
DeKalb County Medical Society Councilor—Not Referred
Fulton County Medical Society Councilor (Godwin)—Not Referred
Georgia Medical Society Councilor—Not Referred
Muscogee County Medical Society Councilor—Not Referred
Richmond County Medical Society Councilor—Not Referred

ASSOCIATION COMMITTEES

Annual Session—Reference Committee D
Constitution and Bylaws—Reference Committee B
Finance—Not Referred
Professional Conduct and Medical Ethics—Not Referred
Emergency Medical Services—Not Referred
Woman's Auxiliary Advisory—Reference Committee D
Allied Health Careers—Reference Committee C
Areawide Health Planning—Not Referred
Cancer—Reference Committee A
Historical—Not Referred
Insurance and Economics—Reference Committee A
Legislation
National—Reference Committee B
State—Reference Committee B
Maternal and Infant Welfare—Reference Committee D
Medical Education—Not Referred
Medical Review and Negotiating—Reference Committee C
Medicine and Religion—Not Referred
Mental Health—Not Referred
Nursing Liaison—Reference Committee D
Occupational Health—Not Referred
Physician-Lawyer Liaison—Reference Committee C
Private Practice—Not Referred
Public Relations—Reference Committee A

Rural Health—Not Referred
School Child Health—Not Referred
Study Medical Practice Act—Reference Committee C
Quackery—Reference Committee B

SPECIAL REPORTS

Report of the *Journal*—Not Referred
Woman's Auxiliary to the Medical Association of Georgia—Not Referred
Georgia Regional Medical Program—Reference Committee A
Operational Projects, Georgia Regional Medical Program—Not Referred
Georgia Medical Care Foundation—Reference Committee C

Speaker Rogers then took note of the fact that 1971 would be the first time that the headquarters staff had annotated the reports with previous actions of MAG where there were recommendations contained in the reports and announced that complete previous actions as indicated would be available to the appropriate Reference Committees by the MAG staff.

Speaker Rogers then called attention to the reports which were shown as "Not Referred" and stated that these were excellent reports containing information on projects and activities in progress or already completed. Speaker Rogers then recognized President F. G. Eldridge for the purpose of a motion regarding those reports "Not Referred."

President Eldridge then explained that he asked the privilege of the floor to express his sincere appreciation to the Officers, Councilors, Committee Chairmen, and the AMA Delegation who had served during his administration. He pointed out that it had been the combined work of all those leaders that had produced a successful year for the Medical Association of Georgia and an enjoyable year for him personally as President. President Eldridge stated that those individuals had reported to him and to the House of Delegates through the excellent reports appearing in the Delegates' Handbook and emphasized that this had been a most interesting year; instead of recommendations by Committees and Officers, that the reports of Committees and Officers reflected many accomplishments resulting in fewer items being brought before the Reference Committees and the House of Delegates for debate. President Eldridge then moved that the First Session of the House of Delegates adopt with commendation all reports not specifically referred to Reference Committees for further consideration.

This motion was duly seconded and passed, and Speaker Rogers announced that all reports indicated as "Not Referred" were adopted with commendation as follows:

President

F. G. ELDRIDGE, M.D., *Valdosta*

Each Committee of the Medical Association of Georgia submits and publishes a report of the year's activity and accomplishments through its Chairman for the information and edification of the House of Delegates in particular and the membership in general. These reports are detailed and comments by a retiring President are somewhat redundant; however, having met and sat with these Committees, I feel I would be remiss in not recognizing these dedicated individuals for their untiring efforts and many accomplishments.

The Presidency of the Medical Association of Georgia is a working assignment and in no respect can be considered simply a titular position, after almost a year of meeting with various committees of the Medical Association, American Medical Association, Political Action Groups, Board of Health, Board of Medical Examiners, Governor's Conference Committees, Third Party Carriers, etc. I find that MAG stands tall in both State and National circles.

The Georgia Delegation—AMA Delegates and others—occupies a position of high regard and well above the average among the 50 State Delegations. Due to the excellence of your delegation and the respect for its members, your President was selected to represent the Southeastern States as a member of the Steering Committee of the Organization of State Medical Association Presidents. To have been selected as Chairman of this group was a signal honor for Georgia.

Our Regional Medical Program is among the top 10 in the nation and has been afforded such recognition for its organizational excellence and accomplishments and many of our sister states have modeled their programs along the same lines.

Our Insurance and Economics Committee has functioned in such a manner that we experience, and are favored with, the lowest premium rates in the nation for liability insurance.

The Medical Review and Negotiating Committee has spent long and tedious hours in behalf of members to correct errors of administration of governmental programs and to adjudicate claims. This Committee will have a name change to the "Peer Review Committee" and will become a policy body in next year's organization and will be directly responsible for policy and true peer review.

The Committee on Maternal and Infant Welfare submitted a questionnaire regarding the views on abortion and approximately 60 per cent of our membership responded to the questionnaire. This information will allow the members of the Medical Association of Georgia to have a true policy on abortion, rather than an estimate, based on the facts existent throughout the State.

The Legislative Committee is a superb group and all reports point to acceptance by our Legislators that the integrity and honesty is unquestioned and that advice and counsel is always accurate and acceptable.

The annual meetings of our Medical Education Committee, with addition of the County Society and Indoc-trination Conference and the Committee Conclaves, were tremendous successes this past year.

The full cooperation of the Constitutional Boards of Georgia—the Board of Health, the Composite Board of Medical Examiners, the State Medical Education

Board, and others—has been a source of enjoyment even though a few rather difficult problems presented themselves during the course of the past year. A continuation of our close liaison and trust should be continued and enlarged with each and every medically oriented commission or board.

Other standing and special committees have functioned in accordance with their assignments and have done ably and well.

The Woman's Auxiliary has been very active this year and has increased its membership by some 400 members; continued support is necessary and should be given by all members of the Medical Association of Georgia.

The Annual Sessions Committee has instituted a new format and attendance at our Jekyll Island meeting was well above average. The programming was excellent. This year I predict registration will exceed any previous session in both attendance and interest.

Our Headquarters Staff is one of, *if not the best*, of any of our sister States! Efficiency, courtesy and service is outstanding. As we increase in size and provide more and more services to our members, consideration must be given to increase in personnel, especially more field service—one person cannot do justice to an organization as large and as extensive as ours.

If required to select the most outstanding event or innovation of the past year, the selection would have to be the incorporation and institution of our Georgia Medical Care Foundation, Inc. Please read the report of this organization carefully as it places the Doctors of Georgia in a position to guide, direct, guard and protect the interests of our patients and of our members. This organization may well affect our destinies.

President-Elect

W. C. MITCHELL, M.D., *Smyrna*

As President-Elect of the Medical Association of Georgia for the past year, it has been my privilege as well as duty to attend both the quarterly Council meetings of the Executive Committee of the Association.

I did miss the first Executive Committee meeting which was held in conjunction with the American Medical Association meeting in Chicago. Since this meeting came so soon after our annual meeting in May, it was impossible for me to make arrangements to attend.

Since that time, I have not missed any of the meetings. I was, and enjoyed being, a part of the Georgia Delegation to the Clinical Session of the American Medical Association which was held in Boston, Massachusetts in November of 1970.

I feel that I have had the full treatment of indoctrination of the President-Elect and look forward to the office that is to follow in the coming year.

Since it will be my privilege to address the first General Session of the Association, I will forego any recommendations in this report, and embody them in my remarks at that time.

First Vice President

F. W. DOWDA, M.D., *Atlanta*

I would like to thank the members of the House of Delegates and the members of the Medical Association

of Georgia who have permitted me to serve as your Second Vice President and your First Vice President over the last two years.

The opportunity to serve on the Executive Committee of the Medical Association of Georgia and to serve as a voting member of the Council of the Medical Association of Georgia has indeed been a gratifying experience and after this period of time, I am convinced of two things:

(1) The members in the House have been wise in their selection of leadership.

(2) The mechanical structure of the Medical Association of Georgia is an extremely adequate one at this time for handling the affairs of the Medical Association and I see no need for radical or drastic change. The adequacy is due, in large part, to the sense of continuity which the Councilors who may be re-elected year after year give the Council of the Medical Association of Georgia. I think this particular structure has produced gratifying results in our situation and I see very little reason for major modification.

Second Vice President

HENRY D. SCOGGINS, M.D., *Augusta*

The past year I have looked upon as my year of indoctrination. I have been most impressed with the way the affairs of the Medical Association of Georgia are handled so efficiently by the administrative staff.

I have no recommendations but would like to bring up for information the possibility of publishing the dates of the Executive Committee meetings at least three months in advance or preferably six months. This would allow for better attendance by those of us not residing in Atlanta.

AMA Delegates

J. W. CHAMBERS, M.D., *LaGrange*

Mr. Speaker, the Medical Association of Georgia delegation to the American Medical Association reports both the annual session in Chicago and the clinical session in Boston of the AMA House of Delegates in 1970 adequately and effectively covered for the Medical Association of Georgia. As a delegation, we participated in both debate and discussion in all reference committees and where necessary and indicated, on the floor of the House. That both these sessions were busy sessions can be readily shown by the annual session having considered over 80 reports of various kinds and over 100 resolutions and in the clinical session, the AMA House considered more than 30 reports and more than 70 resolutions. The discussion in the sessions covered the full range of business affairs for the AMA from budgets to public relations and Federal legislation.

During the annual session last June, the long discussed report on the Committee on Planning and Development, which our Association submitted a long report to the House on, was finally disposed of to our satisfaction to some degree and the House of Delegates established a Council of the AMA House of Delegates on long-range planning and development. This report and items associated with it probably represented the most debated particular part of the business of the House during the annual session.

During the clinical session in Boston in the fall, the subject of Peer Review and Federally Proposed Peer

Review Organizations, including the Bennett amendment which at that time was before Congress, were discussed at great length.

I believe that this House would like to know that Dr. J. Frank Walker continues to serve with distinction as the vice-speaker of the AMA House of Delegates and that three members of our Delegation during 1970 served on reference committees.

We are proud to represent the Medical Association of Georgia in the AMA House and we would earnestly request the members of the House to earnestly encourage the members of their societies to attend more sessions of the AMA and to observe the AMA House of Delegates in action. We strongly believe this would give every physician in Georgia a better understanding of the function of organized medicine and what the Medical Association of Georgia and the AMA does for every physician.

Since this report does not require referral to a reference committee, Mr. Speaker, the members of the AMA delegation will be available on the floor of the House for any of the members to ask questions or to seek information.

Chairman of Council

CHARLES E. BOHLER, M.D., Brooklet

As Chairman of Council for the year of 1970-71, I wish to submit a brief report of actions taken by Council during this period.

Highlights of Council and the Executive Committee Meetings are reported in detail in the *Journal of the Medical Association of Georgia* and minutes are available on request at MAG headquarters.

As Chairman of Council, I wish to take this opportunity to express the sorrow we all feel because of the deaths during the past year of Ernest E. Proctor of Newnan, Sixth District Councilor; Roy C. Gibson of Columbus, Muscogee County Medical Society Councilor and Louie H. Griffin of Claxton, recently First District Vice Councilor. Men of their caliber are not easily replaced and there will long be a void at our meetings because of the absence of these friends and fellow Councilors. I sincerely hope we never again experience a year during which we lose so many of our good friends and fellow workers.

During this year, we voted to accept Doctors of Osteopathy to membership in MAG and approved an implementing amendment, drafted by the Committee on Constitution and Bylaws for submission to the House of Delegates. We adopted a policy statement declaring professional relationship with Doctors of Osteopathy holding full practice privilege licenses to be ethical.

At the September 1970 Council meeting, one of the most important actions was the decision to incorporate the Georgia Medical Care Foundation, a document which will probably prove to be very beneficial for preservation of the concept of free choice of physician and hospital by the patient and the fee for service concept. This document and its function will be explained to all members of MAG through the *Journal* and by individual mailings.

Council has endeavored to implement the directives from the House of Delegates. These actions are reported in detail in the published minutes of Council. Under the persistent and dedicated proddings of Harrison

Rogers, Speaker of the House of Delegates, we have attempted to carry out these directives.

During this year, our MAG Occupational Health Committee persuaded the State Workmen's Compensation Board to pay physicians their usual and customary fees. MAG's Medical Review and Negotiating Committee will review unusual cases for the State Workman's Compensation Board and/or dissatisfied physicians.

MAG's Committee on Medical Review and Negotiating, a very dedicated and hard-working committee, drew up and published a Policy Manual on Peer Review. This manual has been carefully studied by the Executive Committee and Council and accepted as a guide-line for peer review.

Council has had a busy year. I feel much has been accomplished.

We have had excellent cooperation from the Woman's Auxiliary and the president, Mrs. Charles Smith (Myrtle), has attended all Council meetings and has been most helpful.

Members of Council are dedicated to working long hours for MAG. I feel it is unfortunate that so few members of MAG attend our meetings to learn first-hand what goes on. I feel we should encourage new members of MAG to attend both our annual session and a meeting of Council in order to fully understand the workings of our organization.

MAG would soon wither on the vine were it not for the excellent staff we have at Headquarters. These people are most dedicated and conscientious people who always get the job done. Their devotion to their work is highly commendable.

This concludes my second year as Chairman of Council and I wish to express my sincere appreciation for having had this honor.

First District Councilor

CHARLES E. BOHLER, M.D., Brooklet

As Councilor from the First District, I have attended all meetings of the Council during the past year. I have attempted to keep the component Medical Societies in my district abreast of MAG policy and of Council and Executive Committee action.

The First District meeting this year will be held in Statesboro during April.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Ogeechee River				
Robert L. Pence				
Metter	19	17	22	20
Burke				
Charles G. Green				
Waynesboro	7	5	7	5
Emanuel				
H. Wilder Smith				
Swainsboro	6	5	7	5
Laurens				
Grady E. Longino				
Dublin	41	22	41	21
Screven				
Gerald B. Hogsette				
Sylvania	5	5	5	5

Southeast Georgia				
William W. Aiken				
Lyons	18	13	21	14
	96	67	103	70

Second District Councilor

J. DANIEL BATEMAN, M.D., *Albany*

SECOND DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Colquitt				
R. M. Joiner				
Moultrie	16	13	16	13
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	17	8	16	8
Dougherty				
Edwin E. Flournoy, Jr.				
Albany	61	49	60	49
Mitchell				
A. A. McNeill, Jr.				
Camilla	5	5	7	7
Southwest Georgia				
M. N. Laslie				
Blakely	12	11	12	10
Thomas-Brooks-Grady				
F. G. Osborne				
Thomasville	55	47	53	44
Tift				
Joe M. Turner				
Tifton	20	16	17	12
Worth				
Robert T. Morgan				
Sylvester	5	5	5	5
	191	154	186	148

Third District Councilor and Vice Councilor

J. T. CHRISTMAS, M.D., *Vienna, Councilor*, and
JOHN H. ROBINSON, III, M.D., *Americus,*
Vice Councilor

One or both of us have attended all regular and called meetings of Council throughout the year 1970 and have participated in the functions of Council. In addition, one of us, J. T. Christmas, M.D., has been appointed by Council as a Director of the Georgia Medical Care Foundation, has attended all meetings of the Board of Directors of the Georgia Medical Care Foundation. Throughout the year the Councilor has attended several of the local medical society meetings for the purpose of giving a report of Council's activities and explaining the purposes and functionings of the Georgia Medical Care Foundation to the local societies. The Vice Councilor attended the Annual Leadership Conference and the Fourth Georgia Conference on Medical Education.

The Third District regular annual meeting was held in October in Cordele with very good attendance and good program. New officers were elected and the membership voted to have one annual meeting regularly

rather than two meetings a year and to endeavor to have an outstanding scientific program at this meeting.

The death of Dr. Roy Gibson, of Columbus, has created a vacancy on the State Board of Health from the Third District. Three names have been submitted to the Council from the Third District to fill this vacancy, and these names have been submitted to the Governor. It is anticipated that by the time this report is published that the Third District member of the Board of Health will have been named.

We have no recommendations to offer the House of Delegates at this time that have not already been covered elsewhere.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Flint				
Robert E. Barr				
Cordele	16	14	16	14
Peach Belt				
R. D. Severs				
Warner Robins	36	34	34	32
Randolph-Stewart-Terrell				
Carl E. Sills				
Cuthbert	12	11	12	11
Sumter				
William R. Anderson				
Americus	31	26	26	20
	95	85	88	77

Sixth District Councilor

NORMAN P. GARDNER, M.D., *Thomaston*

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Clayton-Fayette				
F. A. Sams, Jr.				
Fayetteville	11	10	8	7
Coweta				
Thomas C. Graham				
Newnan	20	14	22	14
Meriwether-Harris				
J. L. Robinson				
Woodbury	15	13	15	13
Spalding				
Robert Proctor				
Griffin	47	44	44	39
Troup				
Stevens Byars				
LaGrange	39	33	40	35
Upson				
A. M. Holloway				
Thomaston	19	15	19	16
	151	129	148	124

Seventh District Councilor

DAVID A. WELLS, M.D., *Dalton*

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bartow				
W. C. Holmes				
Cartersville	10	6	10	6
Carroll-Douglas-Haralson				
Joe E. Parrish				
Carrollton	37	35	38	36
Floyd				
Tom Moss, Jr.				
Rome	87	76	85	76
Gordon				
W. R. Thompson				
Calhoun	9	8	9	8
Polk				
Ben Anderson				
Cedartown	13	11	14	12
Walker-Catoosa-Dade				
Richard Cureton				
Ft. Oglethorpe	37	24	35	20
Whitfield				
R. T. Farrow				
Dalton	40	32	40	36
	233	192	231	194

Eighth District Councilor

ROBERT E. PERRY, JR., M.D., *Brunswick*

I have attended Council meetings as well as all District meetings of my District. Attempts were made to clarify the misunderstanding among the members concerning the cutback in reliable fees for Medicare. Also, attempts were made to inform the District members of activities of the Council and Medical Association of Georgia.

At this time no special recommendations are made.

EIGHTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Altamaha				
Chester B. Kanavage				
Baxley	6	6	7	7
Ben Hill-Irwin				
Morgan Smith				
Fitzgerald	8	8	8	8
Coffee				
T. K. Stapleton				
Douglas	9	7	10	7
Camden-Charlton				
H. H. Robinson				
Kingsland	9	5	10	7
Glynn				
Hurley Jones				
Brunswick	49	43	46	43

Ocmulgee

William E. Coleman				
Hawkinsville	16	14	16	13
South Georgia				
James Mathis				
Valdosta	59	45	58	43
Telfair				
D. B. McRae				
McRae	5	4	5	4
Ware				
Edward Brown				
Waycross	41	37	43	40
Wayne				
Ollie O. McGahee, Jr.				
Jesup	13	9	9	9
	215	178	212	181

Ninth District Councilor

PAUL T. SCOGGINS, M.D., *Commerce*

NINTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Barrow				
J. K. Adams				
Jefferson	9	8	8	7
Blue Ridge				
H. E. Mitzelfelt				
Blue Ridge	6	5	6	5
Chattahoochee				
R. H. Bramblett				
Cumming	21	16	21	16
Cherokee-Pickens				
D. T. Darnell				
Tate	14	14	14	13
Elbert-Franklin-Hart				
L. G. Caccholi				
Hartwell	18	12	19	10
Habersham				
F. O. Garrison				
Demorest	15	11	18	14
Hall				
Gerald L. Watts				
Gainesville	64	61	63	58
Jackson-Banks				
S. A. Vickery				
Commerce	9	7	10	7
Stephens				
John C. Lawrence				
Toccoa	23	20	21	20
	179	154	180	150

Tenth District Councilor

EDWIN W. ALLEN, JR., M.D., *Milledgeville*

I have attended all of the MAG Council meetings scheduled during 1970-71, as well as the two meetings of the Tenth District Medical Society. The possibility of the revocation of the Charter of the Jefferson County Medical Society was referred to me for investigation but because there is a Life Member in the Society, they are still on an active status and will remain so until after the Annual Session when a decision is made by the

House of Delegates on whether Life Members have all the privileges of an active member.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Baldwin				
William Howard				
Milledgeville	43	33	38	31
Crawford W. Long				
William Mulherin				
Athens	72	54	68	52
Jefferson				
C. Roy Williams				
Wadley	5	4	5	4
McDuffie				
T. E. Averitt				
Thomson	7	6	7	6
Newton-Rockdale				
R. L. Faulkner				
Covington	12	7	12	7
Oconee Valley				
L. J. Wade				
Union Point	13	11	11	8
Walton				
Robert M. Tankesley				
Monroe	10	9	10	9
Washington				
William Taylor				
Tennille	11	4	10	2
Wilkes				
A. D. Duggan				
Washington	6	5	6	5
	179	133	167	124

Bibb County Medical Society Councilor

BRASWELL E. COLLINS, M.D., Macon

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bibb				
Lil James				
Macon	183	151	184	153

DeKalb County Medical Society Councilor

M. FREEMAN SIMMONS, M.D., Decatur

FOURTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
DeKalb				
S. Angier Wills				
Decatur	222	199	213	194

Fulton County Medical Society Councilor

JOHN T. GODWIN, M.D., Atlanta

The activities of the Councilor have continued as in

the past with attendance at various meetings and committees throughout the year.

FIFTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Fulton				
William L. McDougall				
Atlanta	1175	960	1167	938

Georgia Medical Society Councilor

L. RICHARD LANIER, M.D., Savannah

I have attended the meeting of the Council during my term of office.

During the past year, the Georgia Medical Society has continued its active scientific program with a variety of subjects, speakers and forums.

The Constitution and Bylaws with extensive thought and work, were revised and presented to the Council for its approval.

A survey of the medical community reveals that practically all eligible physicians in our district are members of the Georgia Medical Society at this time, with only one resignation due to non-payment of dues experienced by the Georgia Medical Society.

I have no recommendations to be placed before the House of Delegates.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Georgia Medical Society				
H. H. McGee, Jr.				
Savannah	188	172	170	152

Muscogee County Medical Society Councilor

ROY L. GIBSON, M.D., Columbus

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Muscogee				
Jack Lawler				
Columbus	133	112	127	113

Richmond County Medical Society Councilor

J. L. MULHERIN, M.D., Augusta

During the past year, the Richmond County Medical Society has been represented at every Council meeting by either the Councilor or the Vice-Councilor.

I have no specific recommendation to make but I endorse the resolutions which will be presented from the Richmond County Medical Society; namely a meeting between local county medical society officers and their legislators prior to the General Assembly to discuss matters pertaining to medicine and health care; and the sending of Delegates Handbooks to alternate delegates and vice-councilors prior to each annual session of MAG.

I would like to take this opportunity to thank the members of the staff of MAG for their loyal and dedicated work during the past year.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Richmond				
J. K. McDonald				
Augusta	310	271	292	250

Cancer Committee

HOKE WAMMOCK, M.D., *Chairman*

The Committee on Cancer met during the time of the Committee Conclave and has another meeting scheduled before the Annual Session, and therefore will not be able to submit a complete report at this time. However, the Committee did take a stand on various topics, and these will be reviewed in this report. Any further actions will be presented in an addendum to the House of Delegates.

The Committee has approved the 1971, 1972 and 1973 priorities of the Regional Medical Program Cancer Control. Also, as radiation therapy is becoming an increasing problem in the continuation and establishment of new area facility programs and radiation therapists are required to provide adequate and proper irradiation therapy, the Committee on Cancer has recommended that a radiation therapist be added to the Steering Committee of the Regional Medical Program.

The Committee realizes its responsibility in promoting and coordinating the activities of cancer control in the State and gives endorsement to the activities of the present area cancer facility programs of the Regional Medical Program. It feels that there should be other area cancer facilities approved as soon as possible, with such approval following the pattern of the established rules and regulations of the American College of Surgeons. The Committee has learned of the activities of the Blue Cross and Blue Shield in supporting some clinical activities in the field of cancer in the state of Iowa and feels that this matter should be pursued in the state of Georgia. Some additional support might be obtained from Blue Cross and Blue Shield and perhaps private insurance carriers for the activities of the cancer clinical programs and the secretarial assistants for Tumor Registries, etc.

The Committee on Cancer reviewed the structure of the members of the State Board of Health and felt that there should be some member of this Board who is strictly oriented to cancer. Efforts should be made to see that this is accomplished, and it is requested that this be accomplished either through the nomination of the individual from the various congressional districts or from the membership at large.

The Committee also wishes to give its approval and assistance to the "Reach to Recovery Program," instituted in this state through the efforts of Dr. C. R. White, Chairman for the Georgia Division of the American Cancer Control Program. This Program should be pursued to its fullest extent, providing cancer patients with necessary information and assistance in their rehabilitation phase.

The Chairman wishes to express his appreciation to all the members of the Committee on Cancer and to the officers of the Medical Association of Georgia for their cooperation in providing better medical care.

Emergency Medical Services Committee

CARL JELENKO, III, M.D., *Chairman*

ACTIVITIES

The major activities of the EMS Committee of the MAG for 1970 comprised investigation of methods for complying with House Resolution 70-3: Medical System for Mass Casualty situations.

It was determined that this Resolution comprised four parts:

(a) That a Standing Committee be established to create an effective Medical System to assist in Mass Casualty situations.

(b) That the system be reviewed semi-annually.

(c) That a Mass Casualty manual be prepared and promulgated.

(d) That appropriate new programs for coordinating Medical Systems to assist in Mass Casualty situations be developed.

With regard to (a), the Highway and Traffic Safety Committee and the Disaster Medical Care Committees of the MAG were combined into the Emergency Medical Services Committee of the MAG, a Standing Committee, in April 1970, and Carl Jelenko, III of Augusta was elected chairman.

With regard to (b), a survey was undertaken of the placement of Package Disaster Hospitals, Ambulance Services, Emergency Rooms, and the general state of preparedness throughout Georgia by members of the Committee in conjunction with the Emergency Medical Services Division of the Georgia State Department of Health. Re-assessment of medical performance at Byron, Augusta, and Yellow River problems revealed a general lack of community preparedness and hospital pre-planning. Preliminary plans were drafted to institute a Teaching Program designed for Hospital Administrators and Emergency Department nurses and physicians to instruct them and help guide them in organizing their respective facilities in optimum organization to receive Mass Casualty victims.

Considerable effort was invested by the committee in an effort to insure passage by the State Legislature of the Ambulance Statute, in addition to the Georgia Health Code 88-26 which will provide for an almost optimum Ambulance Service throughout the State. In essence, this Statute will require licensing of all ambulances; outfitting of ambulances such that they can administer oxygen, splint fractures, control hemorrhage, and are manned by trained personnel whose training is certified and overseen by the State Department of Health. The Committee through editorials and personal contact with the various Legislatures, Governor, and Lieutenant Governor, and the Chairman of various key Committees was active in a campaign to indicate its strong support for this measure.

The EMS Committee reviewed and strongly recommended to Georgia Regional Medical Programs and the State Department of Health acceptance of a proposed project which would survey and upgrade Ambulance Services in the greater Atlanta area. This program by MACHEALTH, under the direction of Dr. Norman

Berry, is a most imaginative and well conceived project which the Committee strongly supports.

The Committee also was instrumental and supported a coordinated effort by the Valdosta Greater Trade Council which provided for a centralization of Emergency Medical Services through a proposal submitted to Georgia Regional Medical Programs. This proposal provided for upgraded communications, Emergency Department personnel, ambulances, and training for Emergency Medical technicians in an 11-county area in Southern Georgia and Northern Florida. It should be noted, parenthetically, that the proposal was approved by the Facilities and Services Task Force of GRMP which met February 4, 1971; and it is hoped will be approved by the Regional assessment group shortly. This program, once funded, will serve as a prototype of a delivery system for Emergency Medical Services which can be duplicated in many areas throughout the State.

With regard to (c), a great number of Mass Casualty manuals were reviewed by the Committee, which felt that it would be most appropriate to select from existing Mass Casualty manuals one that could be adapted to the needs of the State of Georgia. It was the Committee's decision to select and adapt the American College of Orthopedic Surgeons (ACOS Manual on Emergency Medical Services) for this purpose. Accordingly, several copies have been purchased and appropriate modifications are in process of being studied.

With regard to (d), several newer techniques were investigated by the Committee. In the greater Augusta area, a community-wide effort involving Police and Fire Departments, the Bar Association, the Medical College of Georgia, the city/county hospital, the Red Cross, Civil Defense, and the Department of Public Health have indicated to the Mayor that an Emergency Medical Services Commission would be a useful and welcome entity. The Mayor of Augusta, Ga., is in the process of organizing such a Commission which, it is hoped, will come to fruition in the near future.

The Committee has actively supported Legislation concerning visual acuity and the Medical Advisory Board. Both bills were presented at the 1971 meeting of the State Legislature.

The Committee reviewed, approved, and recommended Council approval of a series of six television tape presentations and kinescope (16mm films) on "The Management of Disaster and Mass Casualties" produced at the Medical College of Georgia. These were presented to Council and approved at the meeting at Sea Island on September 19-20, 1970 with a recommendation that County Society presidents be made aware of the existence of these tapes and the recommendation be made to them that they be shown to their respective societies.

A resolution was made by the Committee and approved by the Executive Committee of Council that a Governor's Commission on Emergency Medical Services be established to study and make appropriate recommendations to those Executive and Legislative Departments and divisions concerned relative to coordinating and improving the delivery of Emergency Medical Services in Georgia. The Executive Committee approved this resolution on January 17, 1971, and the resolution was planned for delivery to the Governor at the close of the Legislative Assembly, approximately April 1971.

FUTURE ACTIVITIES

The Committee planned extensive work in support of and development of the Governor's Commission. Further, development of Valdosta-type systems in other areas of the State including the organization of communications networks and Ambulance Services was also planned. Assuming the adoption of the Ambulance Statute, standards for Emergency Medical Services technicians required development in conjunction with the Georgia State Department of Health, the Medical College of Georgia, Emory University College of Medicine, and the Regional Medical Programs. Also under study will be development of plans for the categorization of Emergency Departments in the State of Georgia. A further program that requires the attention of the Committee is the development of a project for placing signs on the State's highways indicating the location of hospitals in nearby communities. It is probable that the EMS Committee will request the House of Delegates to consider a resolution expressing the concern of the MAG for the emplacement of signs on various Georgia highways indicating the locations of hospitals nearby, but this will be drafted at the April 1971 meeting of the Committee.

NOTE

Co-sponsorship of the courses at the Medical College of Georgia comprised educational efforts on the part of the Committee in that these are the only courses of their type offered in the State devoted to Mass Casualty and Disaster Planning, or to Medical School-based Training of Emergency Medical Technicians.

Professional Conduct and Medical Ethics Committee

T. A. SAPPINGTON, M.D., *Chairman*

Complaints have been received in about the usual number during the past year. All have been referred to the local society for action at the local level, and have been taken care of at that level. There has not been a formal meeting of the committee necessary this year concerning complaints against members.

A resume of all complaints received is being sent to each committee member at quarterly intervals now, so that each will have some knowledge as to the complaints received and what action has been taken.

There has been a recommendation for a slight change in the Bylaws regarding what cases the local societies would refer to the Professional Conduct and Medical Ethics Committee of the Medical Association of Georgia. It is felt that the vast majority of complaints can and should be resolved at the local level rather than being sent to the Committee on Professional Conduct and Medical Ethics of the Medical Association of Georgia.

Council has referred the question of granting hospital privileges to Podiatrists in Georgia to this committee for a recommendation. This question has many ramifications and a called meeting of the Committee was held on February 24, 1971. A majority of the members of the Committee were present and after much discussion it was decided that the Committee would recommend to Council that Podiatrists not be granted hospital privileges in Georgia.

The Chairman attended an AMA Conference on Medical Ethics in Chicago in September, 1970. It was an informative conference. It was felt that the Medical Association of Georgia has fewer complaints against its members as to ethics and conduct than many other states and that our method of handling these complaints is better than in some of the state organizations.

Areawide Health Planning Committee

F. W. DOWDA, M.D., *Chairman*

As your Areawide Health Planning Committee Chairman, I have grown increasingly alarmed at the powers and attitudes of planners in general at all levels of government. I think it is urgent, therefore, that the Medical Association of Georgia in the field of Health Planning, establish priorities in the orderly steps that need to be taken and to push very hard in all matters that are appropriate for the adoption of the particular protocol proposed by the Medical Association of Georgia.

Crippled Children Committee

HARRY R. FOSTER, M.D., *Chairman*

The MAG Committee on Crippled Children met three times in 1970 for the primary purpose of discussing the State Crippled Children Service. It was agreed by the committee that the clinic system is the most satisfactory way of caring for the State's crippled children; however, it was thought that the scope of the program should be broadened to take care of all children with an illness, where there is a chance for rehabilitation.

As the Board of Health was considering the possible restructuring of the entire Crippled Children Service Program, the Director of the Program was asked to attend a committee meeting to discuss the program. Suggestions were made such as a team approach in treating a child, with a pediatrician as the team leader and medical specialists as consultants. There could be complete care centers in geographically selected areas depending on population and medical facilities. This center would be responsible for coordinating the medico-socio-economic needs of the child and family. Certain conditions not covered in the CCS program, such as the hydrocephalic child and the one with renal disease, were suggested for inclusion in the CCS program and the Director stated that an increased budget might be considered for catastrophic conditions. The committee was in agreement that comprehensive medical care for children, who cannot afford medical care, is needed.

At another meeting of the committee representatives of specialty societies interested in the CCS program were invited. It developed from many discussions that there were two philosophies involved—the orthopedists would like to keep control and the pediatricians would like more involvement, both of which are valid. One reason for the exception was that there is a feeling that the orthopedic clinics might be discontinued due to the Board of Health Medical Care Administration Committee's recommendation that a pediatrician should be in charge of each clinic.

Our committee felt that some overall aims and objectives should be outlined before changing the CCS program, with the establishment of priorities of care being

considered. Therefore, the committee voted to request the Board of Health Medical Care Administration Committee to table the report as a working document and to re-assess the entire program after further study including discussions with representatives of all the specialties involved.

Historical Committee

MILFORD B. HATCHER, M.D., *Chairman*

The Historical Committee of the Medical Association of Georgia does not have any outstanding accomplishments to report at this time. The History Department of the University of Georgia is attempting to secure a Professor of Medical History which will expedite the writing of a history of medicine in Georgia. The chairman of your Committee has been in consultation with the members of the Department of History at the University of Georgia and has interviewed some prospective applicants.

The members of the Woman's Auxiliary are busy compiling histories of their respective sections of the State, and this will be an invaluable aid when these facets are all put together. There continues to be liaison with the Stone Mountain Memorial regarding a medical museum in the Stone Mountain Memorial Park. I feel that this will take some time for all of this to materialize. There are no recommendations made at this time.

Medical Education Committee

LUTHER G. FORTSON, M.D., *Chairman*

Mr. Chairman, your Committee on Medical Education has concerned itself with methods of improving the delivery of continuing education to the physicians of Georgia, and to their allied health professionals.

The Fourth Biennial Conference on Medical Education was presented at Callaway Gardens February 26-28, 1971. Topics discussed in depth included: "The Impact of National Health Insurance on the Practice of Medicine"; allied health professions and the team concept in the delivery of medical care; the role of the medical school in development of comprehensive health centers; and rural medicine and the medical schools' contribution to the vanishing practitioner. A complete report will be presented in a forthcoming issue of the *Journal*.

A sub-committee has been appointed to explore possible methods of third-party payers as an educational tool—identification of deficiencies, planning or remedial programs, etc. Their report should be ready for presentation at the committee conclave in August.

The Physicians Recognition Award program of AMA is a worthy one, and most deserving of support. Your Committee will endeavor to publicize this program through a direct mail campaign as well as through a series of presentations in the *Journal*.

A closer relationship between the medical schools and the Committee is desirable; we shall do our best to encourage this, and a committee meeting will hopefully be scheduled at each school each year.

Your Committee Chairman attended the AMA Congress on Medical Education in February; this is being reported in the *Journal*.

Mr. Chairman, your Committee on Medical Education recognizes that the practice of medicine as we

have known it faces new and different challenges each day; we must continue our efforts to develop methods of continuing education which will help all of us to adapt to these challenges with continually increasing excellence.

Mr. Chairman, allow me to express the sincere appreciation of the Committee for the excellent work of the MAG staff; Adam Jablonowski has marshalled staff resources in superb fashion to provide invaluable support to your committee's activities.

Medicine and Religion Committee

W. H. POOL, JR., M.D., *Chairman*

There continues to be considerable interest and activity in matters of medicine and religion over the state of Georgia. Many county medical societies have committees of medicine and religion and law that sponsor programs and seminars. Interestingly, there are several auxiliaries that have committees of medicine and religion and have presented programs for themselves as well as community-oriented projects in their area. The AMA Department has literature and film support for such activities.

The thrust of the AMA division over the next 18 months is to be an effort to work with the various seminaries in each state in developing programs in medicine and religion as part of their curriculum. Subsequently, it is the plan to tackle medical colleges with the same end in view.

The chairman of the committee has engaged in several interesting activities that I hope will benefit the committee next year. I attended the National Prayer Breakfast in honor of President and Mrs. Nixon in Washington, D.C., February 2, 1971. This was the first time that a group of physicians as such were invited. After the breakfast, we had the opportunity to gather as a group and talk informally as well as have presentations by several senators and other representatives of government.

The following weekend in Atlanta there was a meeting of the Regional Medicine and Religion state chairmen, this sponsored by the AMA office. It was a most stimulating meeting. I found that many activities are going on in the southeast, treating the "total man," that are both fascinating and, I believe, very worthwhile. With this background we plan a spring meeting of the Medicine and Religion Committee in Marietta, April 30, in conjunction with a Medicine, Religion and Law seminar being held at Kennesaw Junior College. We will propose efforts in several areas supporting county committees and begin group projects in medical student and seminary programs.

A pilot project to bring some seminary student to the Medical College of Georgia in dialogue with a group of medical students is hopefully far enough along that it can be accomplished the first part of May.

Care of the "total man," although not in the limelight, may well be the most significant development now taking place in the medical field. In spite of all that is being discussed concerning insurance, peer review, etc., those efforts that are moving toward the concept of treating patients as total individuals (physical—emotional—spiritual), which cannot be separated any more than the liver can be separated from the body, may be the most significant.

Mental Health Committee

A. S. YOCHER, M.D., *Chairman*

This Committee has met formally on two occasions this past year. Items pertaining to modifying and updating certain portions of the Mental Health Law were endorsed by this Committee for legislative consideration.

Endorsement was given to redefining and changing certain codes relative to alcoholic and drug abuse problems. One film on drug abuse has been purchased by MAG and is being used effectively.

As a result of our recommendation, a psychiatrist has been appointed to the MAG Legislative Committee. This closer liaison with the Legislative Committee this year has been helpful.

The Committee continues to support its position on helping legislation pertaining to health care and insurance under the medical model.

Occupational Health Committee

TOM S. HOWELL, JR., M.D., *Chairman*

The Occupational Health Committee devoted a majority of its efforts toward achieving recognition of "usual and customary" fees for Workmen's Compensation; the Medical Review and Negotiating Committee was asked to act as a consultant in questionable decisions. This arrangement has been well accepted to date.

The Occupational Health Committee wishes to endorse "unlimited medical coverage" in Workmen's Compensation cases and approves up-dating the Occupational Health Act as introduced in the 1971 Legislature. Plans for 1971 include orientation of industry as regards to occupational respiratory diseases.

Private Practice Committee

DONALD R. ROONEY, M.D., *Chairman*

During the past year this committee has functioned to help preserve the concept of the private practice of medicine. During the MAG Committee Conclave on August 16, 1970 this committee met with 12 in attendance. Objectives of the AMA Committee on Private Practice as well as the MAG Committee were formulated and subsequently distributed to members of this committee. Topics discussed at this meeting included Hospital Medical Directors, Emergency Room Guidelines, Health Maintenance Organizations and the Practice of Medicine by an unlicensed physician at an Atlanta hospital. The last matter was referred to the MAG Executive Committee for consideration.

On September 15, 1970, the committee chairman helped to arrange a meeting with Medicare and Bureau of Health Insurance Officials to help to work out problems with Hospital-based physicians and others billing separately for their professional services. It was felt that this meeting was quite productive.

It is anticipated that the committee activity during the coming year will remain the same as in previous years. This committee stands ready to offer help to hospital-based physicians who wish to practice and bill independently from the hospital. We plan to continue lectures to residents in training on the benefits of private practice.

Rural Health Committee

IRVING D. HELLENGA, M.D., *Chairman*

The Rural Health Committee has had particular assistance from Dr. Tom Lumsden, recently made a member of the Council on Rural Health of the American Medical Association. The Sixth Annual Georgia Rural Health Conference was held at the Alpine Lodge in Macon on September 9 and 10 of 1970. The Rural Health Advisory Committee, composed of members of related organizations, was also of material assistance in developing the program of the conference. Among the several highlights were some dramatic addresses given by experts in the field of home poisoning and accident prevention, use and abuse of pesticides, and recreational safety. We also had a most enlightening address about the Rural Development Center at Tifton, Ga. In addition, the work of county nutritional councils serving as pilot projects in several Georgia counties was highlighted.

Emphasis during the Conference was given to the necessity for Medical Allied Health Recruiting. We also had some competent advice from authorities in the field of pre-school hearing and vision screening.

The assistance of the Georgia Farm Bureau and the Cooperative Extension Service of the University of Georgia was gratefully received. We anticipate the continued help of these two organizations and from personnel of related organizations, as we anticipate our 1971 Seventh Annual Rural Health Conference. This will be held once again in Macon, on August 25 and 26 of this year. The program plans are well underway and we anticipate a successful meeting.

Of particular importance for this year is the program of the 24th National Conference on Rural Health, to be held at the Atlanta Marriott Motor Hotel on March 25 and 26 of this year. This is the first national conference on rural health to be held in Georgia, and plans have been underway for a number of months, under the direction of the AMA Council on Rural Health. Dr. Bond Bible, secretary of the Council, has had the cooperation of Dr. Lumsden and many other medical authorities in the Atlanta area, as he has planned the program. The theme of this conference is "Community Health Programs for Tomorrow." The program includes a panel: "Some New Members of the Health Team"; an address: "Medical School Involvement in Community Medicine"; a series of sections dealing with health as a community affair and with the new physician in rural practice; and an evaluation of the effect of the Regional Medical Program on Rural America. At the same time, a discussion of emergency health services in rural areas will be a portion of this program.

The Medical Association of Georgia Committee on Rural Health appreciates greatly the fine cooperation of the Staff of MAG as it carries out its program, particularly the cooperation of Mr. Carl Bailey, whose service has been invaluable.

School Child Health Committee

FRED L. ALLMAN, JR., M.D., *Chairman*

The function of the School Child Health Committee of the Medical Association of Georgia during the past year as in previous years has been to stimulate cooperation by individual physicians and the School Child

Health Program, to keep the profession informed of the school health program and to report to the profession on the progress. Our committee has improved its relation with the Dental Association, the public school system, the Health Department, parents groups, Georgia High School Coaches Association and other appropriate organizations. Specifically, the committee has accomplished the following during the past year:

1. FOLLOW-UP ON EXISTING PROJECTS

a. Smoking and Health: The teacher resource kits which were placed in the schools in 1967 in cooperation with the State Department of Education and the Georgia Heart Association, the Georgia Tubercular Association, the Georgia Cancer Society and the State Health Department have continued to be utilized in many schools throughout Georgia and have been used as a model for other states.

b. Postgraduate Course: The Medical Association of Georgia, through the Committee on the Medical Aspects of Sports and the School Child Health Committee, again sponsored a postgraduate course on the medical aspects of sports. Members of the committee, other members of the Medical Association of Georgia, athletic trainers from the University of Georgia and Georgia Tech presented a very interesting and worthwhile program in Macon, Ga., last August. Again, the highlight of the meeting was a luncheon which was co-sponsored by the Health Department under the supervision of Mrs. Mary Helen Goodloe and the Coca-Cola Company. More than 100 coaches and physicians attended the luncheon and participated in an informal discussion on "Nutrition for the Athlete."

c. News Release: A news release was sent to all of the news media throughout the state in August concerning the safe methods of conducting athletic practices and events in hot, humid weather. This item received very good distribution and helped to prevent heat deaths in the state last year.

2. OLD PROJECTS NOT YET COMPLETED

a. Pre-school Screening of Vision and Hearing: As approved by the Medical Association of Georgia last year, a board has been established consisting of two representatives of the Georgia Society of Otolaryngology, two representatives of the Georgia Society of Ophthalmology, one representative from each of the two medical schools, two representatives of the Medical Association of Georgia and a representative of the Medical Advisory Committee of the Georgia Society for the Prevention of Blindness. It is the avowed aim of the Board of Directors of the Pre-School Medical Survey of Vision and Hearing to eventually screen each year the entire population of four-year-olds in the state of Georgia. It is felt that a manifold benefit can be received from this service: 1) children with undiscovered handicaps can be saved the emotional damage and needless loss of hearing senses before they enter school, 2) this work is an excellent public relations vehicle for the medical profession, 3) parents can be given the truth about the medical care of the eyes and ears, 4) opportunity to harness in an effective way the services of thousands of volunteers who experience the benefit of personal involvement with children, 5) the financial investment is minor compared with the involvement and working together of professional and non-professional people toward a common goal. A spring meeting

of the advisory committee is scheduled, at which time the plan of action will be outlined and I hope implemented. Before the next meeting of the Medical Association of Georgia, the pre-school medical survey of vision and hearing should become a reality.

b. School Benefit Plan: The committee feels that there are still far too many youngsters participating in athletics throughout the state who do not have adequate insurance coverage to care for them in case of serious injury. This is a problem that directs itself to the medical profession, to the involved schools, to the parents and to the athlete. The committee plans to investigate possibilities of alleviating this potentially harmful situation.

c. The Certification of Coaches: The certification of coaches, with minimum standards of instruction in important subjects such as first aid and other preventative measures, continues to be an important item on our agenda of things that must be accomplished. Also, a criteria of certification of physicians for attendance at athletic events must be given consideration.

d. Round-Robin Seminars Throughout the State Concerning the Proper Medical Aspects of Sports: Due to lack of financial backing, this project could not be initiated during 1970. It is hoped that funds from sources outside of the Medical Association of Georgia will become available and will make this a reality in the near future.

3. NEW PROJECTS

The School Child Health Committee of the Medical Association of Georgia prepared and filmed six 30-minute television tapes which were shown over WGTV during the early part of football season last year. The areas covered were "Why have medical supervision for athletic events," "protective equipment," "conditioning," "acclimatization to heat," "knee, ankle and shoulder injuries." Many favorable comments have been received throughout the state by viewers of this program.

4. NEW PROJECTS

a. New Comprehensive Form for Pre-Participation Physical and Emotional Evaluation of Athletes: A new, much more comprehensive form for pre-participation physical and emotional evaluation of the athletes of our state is currently being formulated. It is hoped that this more comprehensive medical evaluation will include items which relate to the physical readiness of the individual for sports. These would include cardiovascular respiratory fitness, body build, strength tests, measures of flexibility and other indications of physical maturation. It will also place emphasis on emotional readiness for sports as well as to give a classification of sports activity according to the extent of body contact and/or extent of endurance requirements. It is hoped that this project will be completed during the present year.

b. Nutrition Counseling: The committee hopes to participate in a cooperative effort with Mrs. Mary Helen Goodloe of the Department of Public Health in undertaking a pilot project of nutrition counseling which would be directed toward the 1) overweight, 2) underweight and 3) those desiring to increase muscle mass. A format for this program is currently being drawn up.

c. Need for Physical Fitness: The committee feels that a position paper outlining the committee's feeling and policy toward the need of a physically fit popula-

tion, especially as it relates to the school child, is needed. It is now well understood that there is a minimum of physical fitness necessary for healthy living and once fitness drops below this level it may lead to sickness and thus become the concern of physicians. The need for this minimal physical fitness must be met as an important phase of disease prevention and not as a fad. The combination of disuse atrophy, overstimulation and stress produced by a constant inhibition of normal responses has been related to being the basis for a number of diseases which have been termed "hypokinetic diseases" or diseases produced by lack of exercise. The special need for endurance-type activities such as running, cycling, swimming, jumping rope should be encouraged for all school children who are physically capable of such activities. To those who are physically unable to participate in such programs, then alternate programs commensurate with their physical capabilities should be provided.

In concluding, the committee would like to encourage each member of the Medical Association of Georgia to help develop the integrated relationship of health and education. There can be no question that one needs to be educated in order to develop and protect one's health and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician of Georgia.

Speaker Rogers then called attention to four special reports not referred, submitted by the Editor of the *Journal-MAG*, Dr. Edgar Woody; the President of the Woman's Auxiliary, Mrs. Charles R. Smith; the Co-ordinator of the Georgia Regional Medical Program, M. C. Adair, M.D.; and the Director of the Georgia Regional Medical Program, J. Gordon Barrow, M.D.

Journal

EDGAR WOODY, JR., M.D. *Editor*

The 1970-1971 report of the *Journal of the Medical Association of Georgia* is submitted herewith:

PERSONNEL

Since my last annual report I am most pleased to report that there have been no changes in personnel. Miss Pat Thigpen is continuing to do a superior job as our Managing Editor.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

This non-profit bureau in Chicago which solicits and sells national advertising for the state journals continues to do a good job for us. They have maintained an aggressive sales force which continues to effectively represent us in its frequent contracts with national pharmaceutical firms. The readership survey mentioned in last year's report has effectively established the state journals in consistent number three position so far as readership preference is concerned. This survey was carried out by a well-qualified professional survey organization and should prove to be an effective sales tool in the hands of our advertising salesmen.

It is the feeling of the Bureau that advertising volume has probably passed its low point and that we may

reasonably hope for some moderate increase in volume during the coming year.

We are anticipating a seminar to be sponsored by the Bureau in New Orleans in September of this year. These sessions are very stimulating and instructive. They provide an excellent opportunity for state journal personnel to discuss mutual problems and to participate in workshops.

ADVERTISING

Because of the reduced volume of national pharmaceutical advertising available to the *Journal*, a concerted effort is now underway to seek out more local advertising. It is anticipated that this will increase our total advertising volume.

CONTENT

We have been fortunate to receive an adequate number of papers for consideration for publication during the past year. We are continuing to feature clinical conferences from the Medical College of Georgia on an intermittent basis. A series of clinical conferences in the field of radiology is now being prepared from Emory University School of Medicine. An increasing number of letters to the Editor suggests that more members may be reading their *Journal*.

CREDITS

The continuing guidance of the Publications Committee has been a consistent influence in the publication of the *Journal*. Our Contributing Editors have been very helpful in the solicitation and screening of useful material for publication in the *Journal*. Our President's Page continues in the tradition of excellence. Our established specialty pages provide a continuing source of current useful clinical information for our readers. Our excellent Legal Page has helped to guide all of us through these times of change in the practice of medicine. The Headquarters Office staff continues to play their key role in the publication of the *Journal*. Their numerous contributions and suggestions are much appreciated.

The Woman's Auxiliary to the Medical Association of Georgia

MRS. CHARLES R. SMITH, *President*

"Active Leadership in Community Health" was the Auxiliary theme chosen for the year 1970-1971. The need for increasing membership and more active participation of members, a closer-working relationship between the Auxiliary and the medical society has been stressed. I am happy to report that we have increased our membership by 348 and added one more county auxiliary. We now have 2,364 members—39 Auxiliaries and 66 members-at-large. However, unless there are a large number of bachelor doctors in Georgia, there are still many doctors' wives not affiliated with an Auxiliary. We would hope that every doctor would want his wife to be an Auxiliary member and would encourage her to participate actively.

To be an effective leader one must become informal. Through our state meetings and publications, national and statewide, we exchange ideas for a variety of socials, programs and activities. A school of instructions

during the May Convention and two workshops during the year were provided to stimulate and inform our State and county leaders.

At the county level, informative programs concerning such subjects as drug abuse, highway safety, medical legislation, physical fitness, what is happening in health care, how to protect yourself and your home, "Wills and Investments for Women," "Mental Health and Today's Youth," "Responsibility for International Health and Welfare," "Responsibility Toward Our Environment," "Awareness of Contemporary Student Dissent," "Low Cholesterol Diets," "Child Psychology," "Children and Youth" and "Medicine and Religion" were presented. Many of these meetings were joint meetings, several included the whole family and others invited dentists, lawyers and ministers and their wives.

To recruit personnel for medical and allied health careers and to help provide funds for these is still the prime concern of most auxiliaries. Many sponsor health career clubs in the schools. Funds for scholarships have been continued and several new ones established. The William R. Dancy, M.D. Student Loan Fund and the AMA-ERF are strongly supported by all Auxiliaries.

Since the purpose of an Auxiliary is to help medical societies as needed, each Auxiliary considers the needs of its own society and community, then proceeds in appropriate directions. In working toward better public relations, doctors' wives can be helpful in working with worthwhile projects pertaining to health. This past year, auxiliary members have remembered patients at our State Institutions with gifts for birthdays and Christmas, have supplied highchairs, toys and other needed articles to hospital nurseries; visited patients in nursing homes; rolled bandages for the Cancer Society; helped train candy strippers; participated in Garden Therapy at Central State Hospital; volunteered in regional mental health hospitals; purchased washer and dryer for a student nurses' home; one Auxiliary donated 384 man-hours in a crippled children's clinic, this same Auxiliary is getting ready to open a gift shop in their county hospital; worked with P.T.A.'s, Mental Health Associations, Health and Cancer Societies, TB Association and one of our projects requested by the Medical Association of Georgia Committee on Children and Youth has resulted in several thousand children throughout the State having their vision tested and this will be a continual project.

At a request from the Medical Association of Georgia, the Auxiliary is helping in compiling materials on the history of medicine in Georgia.

These are just a few of the highlights of the various activities of the Auxiliary.

I was pleased to find that all Auxiliaries have had at least one, and most of them have had several, joint meetings with their medical society—many of these just for fun. After all, the Number 2 objective of the Auxiliary is to cultivate friendly relations and promote mutual understanding among physicians' families.

The Auxiliary is extremely grateful for your financial support. We are also grateful for the help that we have received from the staff of the Medical Association of Georgia.

I have thoroughly enjoyed being the President of the Woman's Auxiliary to the Medical Association of Georgia and I have especially appreciated the friendship that you and your wives have shown me. To Dr. and Mrs. Eldridge and the members of the Council of the

Medical Association of Georgia, a very special THANK YOU.

All projects and programs sponsored by the Auxiliary, many with the help of the local medical societies, are too numerous to put into this report. They are printed in a complete report for all Delegates to the Woman's Auxiliary to the Medical Association of Georgia.

Georgia Regional Medical Program

M. C. ADAIR, M.D., *Coordinator*

In August, 1970, I succeeded George Alexander as Coordinator of the Georgia Regional Medical Program. He, in turn, followed J. H. Chambers, who had been the original coordinator. Thanks to the efforts of these two men, my work, I am sure, has been easier. The Medical Association of Georgia owes these fine gentlemen a debt of gratitude.

Not too many publicly financed health programs are as medically directed and oriented as our GRMP. We need to continue to show the state and the nation that we can do this type of endeavor.

In Georgia, the Program is responsible for the expenditure of over 1.85 million dollars of public funds annually. Of course accounting and evaluation form important activities to assure that the project funds are expended purposefully.

I note that the representatives of the Medical Association of Georgia to the Regional Advisory Group have not been attending the sessions as well as they should. Since organized medicine (MAG) is the fiscal agent responsible, it is important that our members participate in the policy making activities.

Many worthy elements are on the drawing board. Of interest is the fact that GRMP, at the direction of the Administration, is broadening its interests beyond heart disease, cancer, and stroke. Improving the delivery of health care will receive increasing attention in the future. Since MAG is committed to the improvement of health care delivery whenever possible, we should welcome this activity.

As this is being written, I notice in the *AMA News* that the national Regional Medical Program budget for this fiscal year has been slashed \$34.5 million and that the budget authority being sought for FY '72 contains only \$52.5 million in new funds. Obviously some pruning and redoing will be necessary in Georgia.

RECOMMENDATIONS

- (1) That MAG continue its participation in RMP in a meaningful fashion.
- (2) That MAG members on the Regional Advisory Group more actively participate by attending the meetings.
- (3) That MAG protest the reduction of the FY '71 RMP budget by \$34.5 million and offer the following resolution through proper channels to the AMA.

RESOLUTION

WHEREAS, the Medical Association of Georgia acts as the fiscally responsible organization for the receipt of federal funds to operate the Georgia Regional Medical Program; and

WHEREAS, the Georgia Regional Medical Program has undertaken or is planning to undertake many excel-

lent programs and activities to help the physicians of Georgia improve the health care of the people of Georgia; and

WHEREAS, the physicians of Georgia individually and collectively are involved deeply in the activities of the Georgia Regional Medical Program; and

WHEREAS, the Medical Association of Georgia is totally committed to the continuation and expansion of the Georgia Regional Medical Program; and

WHEREAS, it appears that the majority of state medical associations are involved and committed to continued development of Regional Medical Programs; and

WHEREAS, the 1972 Presidential Budget for Regional Medical Programs has been severely reduced; and

WHEREAS, the Regional Medical Programs are being asked to increase their scope of activities with severely reduced budgets;

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia urges the AMA House of Delegates to charge the Board of Trustees and Staff to exhaust all possibilities in attempting to persuade the Department of Health, Education and Welfare to restore the budget reductions for Regional Medical Programs; and

FURTHER BE IT RESOLVED, that AMA through appropriate channels express to Secretary of HEW Richardson the high degree of commitment that the medical profession has for continued development of Regional Medical Programs.

**Operational Projects of Georgia
Regional Medical Program**

GORDON BARROW, M.D., *Director*

**CLINICAL TRAINING CONFERENCES FOR
PRACTICING PHYSICIANS**

Individually designed postgraduate courses are offered at both Emory University and the Medical College of Georgia, giving physicians an opportunity to return periodically to a teaching institution to participate in educational activity. An important feature of this project is its responsiveness to specific needs of the participants, providing additional training and learning opportunities in those areas where participant physicians indicate a desire for developing new skills.

**POST-RESIDENCY TRAINEESHIPS IN
PEDIATRIC CARDIOLOGY AND IN
HYPERTENSION-RENAL DISEASES**

Courses of study of one year's duration may be designed for those physicians who are not planning academic or research careers. Traineeships are awarded to physicians residing within the region who plan to return to their area.

**VISITING CONSULTANTS PROGRAM TO
COMMUNITY HOSPITALS**

Through this project, consultants are provided to community hospitals either from private practice or from medical school faculty at Emory University or the Medical College of Georgia. Again, the key feature is responsiveness to local needs as identified by local personnel.

INTERLIBRARY COPYING SERVICE

Free photocopying of medical journal articles and free loan of books is provided to community hospitals, physicians and other health personnel through the two medical school libraries.

COLUMBUS MEDICAL CENTER-EMORY UNIVERSITY TEACHING AFFILIATION

A teaching affiliation is provided between Emory University and the Medical Center in Columbus as an attempt to attract additional physicians to that city. The Medical Center is adding to its staff a full-time director of medical education and full-time chiefs of medicine, surgery, gynecology-obstetrics, and pediatrics. These positions will carry Emory faculty appointments.

COMMUNICATIONS NETWORK FOR THE REGION

Continuing education opportunities are provided on an ongoing basis for physicians, nurses, and allied health personnel throughout the region via video-tapes prepared by this project, and, in the Atlanta area, through live TV broadcast. Communications specialists at both Emory University and the Medical College of Georgia participate in this project.

IMPROVEMENT AND COORDINATION OF FACILITIES FOR CARDIOVASCULAR DIAGNOSTIC SERVICES

Facilities for cardiac catheterization, angiocardiography and coronary angiography enable five medical centers to provide these services to other hospitals in the region. Support of this project has equipped cardiovascular laboratories at the centers, greatly enhancing the capability for increasing the number of procedures that can be performed each week.

CARDIOPULMONARY RESUSCITATION PROGRAM

The objective of this project is to develop a cadre of instructors within the organizational structure of the community hospital that will permit them to develop ongoing training activities in their respective communities.

CORONARY INTENSIVE CARE DEVELOPMENT IN SMALL HOSPITALS (CCFS)

This project helps to provide appropriate consultation for small hospitals, through the transmission of monitored ECG's by special telephone line to the nearest medical center with a coronary care unit with trained staff.

STATEWIDE CANCER PROGRAM

Through a statewide system of 12 area cancer facilities in seven localities, programs of consultation, workshops, and continuing education are available for medical professionals. A state registry system of 18 hospital registries is service-oriented for feedback on diagnosis, efficiency of treatment, and follow-up.

PEDIATRIC CHRONIC PULMONARY DISEASE CENTER

The respiratory program of the Department of Pediatrics of the Medical College of Georgia provides consultation services, teaching, and research for chronic and potentially disabling respiratory diseases of children.

TRAINING PROGRAMS FOR MEDICAL SPECIALTY ASSISTANTS

The Medical Specialty Assistants' Training Program based at Grady Hospital, with the cooperation of the Emory University faculty, provides a two-year intensive course to provide assistants to work under the supervision of physicians in coronary care units. Included in the course are electrocardiography, pharmacology, physiology, and electronic monitoring, along with basic nursing care.

COMMUNICATION AND PUBLIC INFORMATION PROGRAM

Information about the Regional Medical Program is provided to interested groups and the public through various communications media—a regular newsletter, audiovisual programs for the use of speakers, and a system of press releases.

PROGRAM REPRESENTATIVES

To facilitate the identification of local needs, the development of new programs to meet those needs, and the administration of ongoing operational projects, a field staff is decentralized throughout the region, divided into five geographic areas. In addition to specific project developmental and monitoring work, program representatives maintain ongoing liaison with local hospitals, physician groups, and local advisory groups in their areas.

AREA FACILITIES FOR CONTINUING EDUCATION

A region-wide network of area facilities for continuing education has been established. The primary responsibility of each facility is to plan, promote, coordinate, and evaluate ongoing programs of continuing education for physicians, nurses, and allied health personnel both in the area facility and in smaller surrounding hospitals.

CORONARY CARE TRAINING

This project has supported the training of both physicians and nurses throughout the region to assure implementation of effective coronary units in this region. Additionally, this project has encouraged the development of standards for coronary care units and the surveying of units for electrical hazards, including the training of hospital personnel to recognize and prevent these hazards.

TEACHING, TRAINING, AND DEMONSTRATION PROGRAM IN HYPERTENSION AND NEPHROLOGY

The goal of this project is to produce a multidisciplinary team for work in conjunction with a nephrologist in combination office-hospital practice in community hospitals, through the institution of training pro-

grams for practicing physicians, RN in renal nursing; renal technologists and technicians, social workers, and dietitians.

PHYSICAL THERAPY FEASIBILITY STUDY

This project has been working on the development and testing of a mechanism for cooperative multi-institutional utilization of physical therapy services. The primary objective is to extend these services into rural areas which have previously not had such services available.

COOPERATIVE EDUCATIONAL AND SERVICE PROGRAM IN CHRONIC PULMONARY DISEASES IN NORTHEAST GEORGIA

This project is centered at Athens General Hospital and provides a training course for inhalation therapy aides from hospitals throughout the region, and provides supervision of their service.

Speaker Rogers then announced that the Report of the Co-ordinator of the Georgia Regional Medical Program contained a specific resolution and referred it to Reference Committee A.

Speaker Rogers then called special attention to the excellent address delivered by Incoming President, W. C. Mitchell, at the First General Session of MAG, Friday, May 14, 1971, and referred it to Reference Committee D.

Speaker Rogers then recognized Dr. Earl T. McGhee, Delegate from Whitfield-Murray County Medical Society, and member of the State Board of Health, for the purpose of a statement to the House of Delegates regarding the recommendation to be made by the Board of Health Committee on Health Care Administration to the full Board recommending that the Board of Health let a contract to the MAG Foundation for the processing of Medicaid claims. Dr. McGhee read a statement and Speaker Rogers announced that a supplemental report of the Council on this subject was prepared and was being referred to Reference Committee C.

Speaker Rogers proceeded with Unfinished Business, calling for submission of Supplemental Reports from Officers, Councilors, or Committee Chairmen.

Supplemental Report 71-1: Committee on Legislation (State)—*Reference Committee B.*

Supplemental Report 71-2: Committee on Cancer—*Reference Committee A.*

Supplemental Report 71-3: Ad Hoc Committee to Study Medical Practice Act—*Reference Committee B.*

Supplemental Report 71-4: Committee on Insurance and Economics—*Reference Committee A.*

Supplemental Report 71-5: Medicaid Contract with Georgia Medical Care Foundation—*Reference Committee C.*

Supplemental Report 71-6: Headquarters Building Expansion—*Reference Committee D.*

Supplemental Report 71-7: Budget for Fiscal Year 1971-72—*Reference Committee D.*

Chairman Rogers then read one item of Old Business tabled until this Session of the House by the 1970 House of Delegates regarding Association Annual Dues and referred this matter of business to Reference Committee D.

Speaker Rogers stated that at this time the House of Delegates would consider New Business which concerned the introduction of resolutions. Dr. Rogers called on the Delegates presenting resolutions to read the BE IT RESOLVED portion of their resolution. The following resolutions were then presented to the House:

Resolution 71-1: Delegates Handbooks to Alternate Delegates—*Reference Committee D.*

Resolution 71-2: County Society Members/Legislators Meeting—*Reference Committee B.*

Resolution 71-3: National Annual Opinion Poll—*Reference Committee A.*

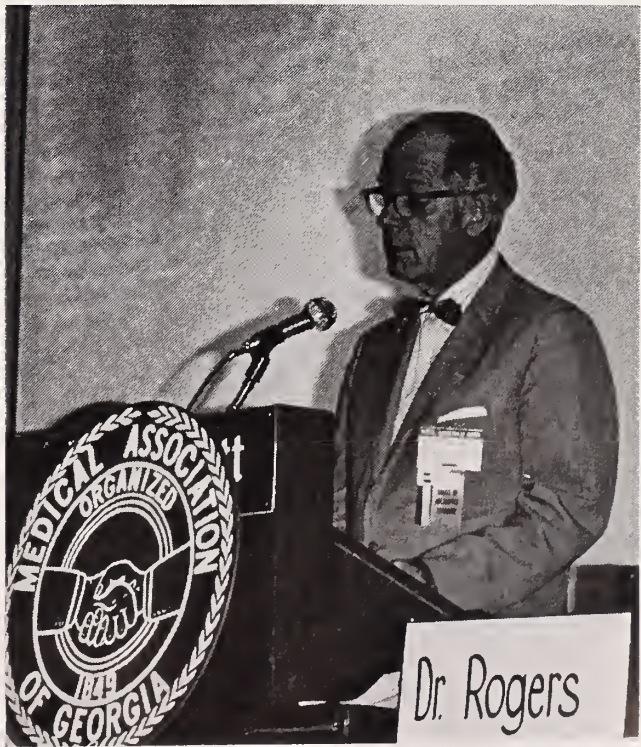
Resolution 71-4: Cessation of Mailing of Unsolicited Drugs—*Reference Committee C.*

Resolution 71-5: Chiropractic Legislation—*Reference Committee B.*

Resolution 71-6: Opposition to Experimental Health Care Delivery Systems Established by HEW—*Reference Committee C.*

Speaker Rogers then called for additional resolutions and there were no additional resolutions received at the First Session of the MAG House of Delegates.

Speaker Rogers then recognized President-Elect W. C. Mitchell, who announced that since Committees had been appointed by the Executive Committee at its April meeting, it would be his privilege to in-



Harrison L. Rogers, Jr., M.D., Speaker of the MAG House of Delegates.

roduce to the House of Delegates the Committee Chairmen who would serve with him during 1971-72. Dr. Mitchell then read the list of MAG Committees and Committee Chairmen and asked those present to stand and be recognized. He then explained the primary purpose of each Committee as follows:

COMMITTEE ON ANNUAL SESSION

Preston D. Ellington

This Committee, of course, has the singular purpose of planning our Annual meetings. That's easy to say, but we all know the tremendous job that statement represents.

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin

This Committee reviews our Bylaws completely every five years, and annually prepares any amendments directed by this House of Delegates or the Council.

COMMITTEE ON PROFESSIONAL CONDUCT AND MEDICAL ETHICS

T. A. Sappington

This Committee serves as our mediation and complaints committee—a sticky job, but with excellent leadership.

COMMITTEE ON EMERGENCY MEDICAL SERVICES

Carl Jelenko

This Committee is concerned with traffic safety and related emergency care and safety matters.

COMMITTEE ON WOMAN'S AUXILIARY

F. G. Eldridge

This is the Committee everyone wants to serve on, but Tex will manage all its "affairs." Seriously, this is an advisory board which counsels the Auxiliary in any way requested.

Special Committees

GOVERNMENT PROGRAMS

F. William Dowda

This Committee is charged with the responsibility of encouraging the participation of physicians in the formation of planning councils in their areas, and monitors Government activities in our State.

BLOOD BANKS

Lee Howard, Jr.

All matters regarding blood bank operation including plasmapheresis centers are referred to this Committee.

CANCER

Hoke Wammock

This Committee attempts to coordinate the many cancer programs in Georgia.

CRIPPLED CHILDREN

H. R. Foster

This Committee is concerned with the Crippled Children's Service in Georgia.

ECOLOGICAL

John Kirk Train, Jr.

This new Committee will deal with all facets of environmental pollution.

HISTORICAL

Milford B. Hatcher

The development of a history of medicine in Georgia will consume this Committee's entire time.

INSURANCE AND ECONOMICS

William W. Moore

This Committee maintains surveillance over all our group insurance plans, and seeks new benefits for the membership.

LEGISLATION

**J. Frank Walker (National)
Harrison L. Rogers (State)**

This Committee handles all legislative matters with both the Congress and the State General Assembly.

MATERNAL AND INFANT WELFARE

Eugene L. Griffin

This Committee studies all maternal and fetal deaths in the State.

EDUCATION

J. Rhodes Haverty

This restructured Committee guides all matters of education, including continuing education, student liaison, and sponsors a biennial conference.

PEER REVIEW

John R. McCain

This is currently our most active Committee, having responsibility for peer review policy and appeal.

MEDICINE AND RELIGION

W. H. Pool

Liaison with the clergy to develop methods of treatment of the whole man is this Committee's duty.



C. L. Ayers, M.D., of Toccoa, M.A.G.'s most senior member.

MENTAL HEALTH

A. S. Yochem

This Committee is concerned with Georgia's mental health program including drug dependence and abuse.

OCCUPATIONAL HEALTH

Tom S. Howell, Jr.

This Committee is concerned with industrial medicine and Workmen's Compensation matters.

PHYSICIAN-LAWYER LIAISON

J. Frank Walker

Surveillance of relationship guidelines is the continuing responsibility of this Committee along with a corresponding group from the Georgia Bar.

COMMUNICATIONS

F. G. Eldridge

The County Society Officers Conference, news media relations, public relations and member information are the responsibility of this Committee.

RURAL HEALTH

Irving D. Hellenga

This Committee concerns itself with health care delivery and opportunities in rural areas of our State, plus liaison with 4-H, Grange, Farm Bureau and other rural oriented organizations.

SCHOOL CHILD HEALTH

Fred L. Allman

The Annual Conference on Medical Aspects of Sports and supervision of Statewide pre-school vision and hearing testing are this Committee's main responsibilities.

SEPARATE BILLING

Donald R. Rooney

Hospital-based physician contracts and emergency room staffing are continuing concerns of this Committee.

TALMADGE HOSPITAL LIAISON

C. Emory Bohler

This Committee stands ready to assist that dynamic institution with any problem.

QUACKERY COMMITTEE

James Kaufmann

The Committee on Quackery is planning a big job for itself in the next legislature, when we hope to undertake an offensive campaign against quackery in our State.

FINANCE

Braswell Collins

The Finance Committee, appointed by the President each year, has that awesome responsibility of determining the level of MAG's annual budget.

AWARDS

John S. Atwater

The Awards Committee is a secret committee, and its secret Chairman is John Atwater. Seriously, the separate secret committee which functions during each Annual Session is not necessarily John's committee which has the responsibility for supervision of MAG's awards criteria.

Dr. Mitchell then stated that other Committees would be appointed during the year as needed and reminded the Delegates that the new Chairman of the Committee on Finance would be selected by the Chairman of Council at its organizational meeting on Sunday, May 16. Dr. Mitchell then asked that the present Committee on Awards continue and also asked that Chairman John S. Atwater continue to serve in that capacity.

Speaker Rogers then thanked the Delegates serving on the Credentials Committee, the Tellers Committee, and the four Reference Committees, and on noting that the business of the First Session of the House of Delegates had been completed, he adjourned the First Session of the MAG House of Delegates on motion duly made and seconded at 11:55 a.m., until Sunday morning, May 16, when the Second Session of the 1971 House of Delegates would be convened to consider Reference Committee reports. Speaker Rogers then turned the gavel over to President Eldridge to convene a special General Assembly program.

MAG General Assembly

117th Annual Session of the Medical Association of Georgia

Friday, May 14, 1971

THE GENERAL ASSEMBLY of the 117th Annual Session of the Medical Association of Georgia was called to order by President F. G. Eldridge, Valdosta, at 12:00 noon, in the North and Center Ballrooms, Marriott Motor Hotel, Atlanta, Ga., on Friday, May 14, 1971.

President Eldridge promised the General Assembly an interesting program and an outstanding speaker. He stated that physicians were concerned with the care and nurture of their patients and thought that those assembled would appreciate the speaker who would present a program on the care and nurture of the physician. President Eldridge then called on the Chairman of Georgia's AMA Delegation, Dr. J. W. Chambers for the purpose of introducing the special speaker.

Dr. Chambers expressed to Dr. Eldridge and the General Assembly his pleasure in having the opportunity of introducing Dr. William Young Rial as follows:

Dr. William Young Rial was born in Newton Lower Falls, Mass., on August 7, 1919. He attended public school in Wilkesburg, Pa. and went on to receive a B.S. in General Engineering from the University of Pittsburgh in 1946, and M.D. from the University of Pittsburgh School of Medicine in 1950. Bill interned at the U.S. Naval Hospital, St. Albans, N.Y., in 1950 and '51 and has been licensed in Pennsylvania since 1951.

Bill does family and general practice in Swarthmore, Pa., and in addition, serves as Clinical Assistant Professor of Medicine at the Medical College of Pennsylvania. Bill is on the active staff of Taylor Hospital in Ridley Park, Pa., and the active staff of the Medical Division of Riddle Memorial Hospital, Media, Pa. He is the Police and Fire Surgeon for the Borough of Swarthmore, his home town, and is a reviewing physician for Philadelphia Blue Cross.

Bill has been active in the Pennsylvania Medical Society and held many offices, including Speaker of the Pennsylvania House of Delegates. He has been President of his County Medical Society, a Delegate to the American Academy of General Practice, Speaker of the House of Delegates of the Pennsylvania Academy of General Practice, and President of the Delaware County Academy of General Practice. He holds committee assignments and presently serves as a Delegate to the AMA from Pennsylvania.

Bill has served his community and his church, his political party and his country, and reviewing his list of activities makes us wonder how he has found the time



William Young Rial, M.D., M.A.G. featured speaker.

to be the good citizen he is. In addition to being a father four times, and now a grandfather, Bill finds fun in skiing, swimming, gardening, photography, classical music and the legitimate theater. We are most pleased to have him with us today, and I wish to present to you now Dr. William Young Rial, who will speak to us on the Care and Nurture of the Physician.

Following the interesting presentation by Dr. Rial, President Eldridge thanked Dr. Rial for his witty and interesting presentation and declared the General Assembly adjourned at 12:50 p.m.

Fourth Annual **COMMITTEE CONCLAVE**

August 7-8, 1971

Sheraton Biltmore Hotel

Atlanta, Georgia

Plan to Attend!

MAG Annual Banquet

117th Annual Session of the Medical Association of Georgia

Saturday, May 15, 1971

THE ANNUAL BANQUET of the 117th Annual Session of the Medical Association of Georgia was held in the Center and South Ballrooms, Marriott Motor Hotel, Atlanta, following a reception sponsored by the Fulton County Medical Society and the Fulton National Bank. President F. G. Eldridge, M.D., Valdosta, presided and served as Master of Ceremonies for the evening.

The invocation was offered by Edwin F. Smith, Executive Director of the Medical Association of Georgia.

Following dinner, President Eldridge introduced those sitting at the head table as follows:

President F. G. Eldridge and Mrs. Eldridge; President-Elect W. C. Mitchell and Mrs. Mitchell; Secretary John Rhodes Haverty and Mrs. Haverty; Chairman of Council C. E. Bohler and Mrs. Bohler; Auxiliary President Mrs. Charles R. Smith and son; Auxiliary President-Elect Mrs. George W. Statham and Dr. Statham; Fulton County Medical Society Auxiliary President Mrs. Milton B. Satcher, Jr. and Dr. Satcher; Fulton County Medical Society President Robert E. Wells and Mrs. Wells; Fulton County Medical Society Local Arrangements Chairman Carter Smith, Jr. and Mrs. Smith; Fulton County Medical Society Auxiliary Local Arrangements Co-Chairman Mrs. George M. Callaway, Jr. and Dr. Callaway, and Fulton County Medical Society Auxiliary Local Arrangements Co-Chairman Mrs. Howard S. Brown, and Dr. Brown.



Mrs. J. Rhodes Haverty, Robert E. Wells, M.D. and Mrs. Charles R. Smith (l. to r.) enjoy Beef Wellington at the Annual Banquet.

President Eldridge then read the following telegram:

"Greetings to the 117th Annual Convention of the Medical Association of Georgia. I'm proud of the work of all doctors in our State. I will need your advice and support to deal with the problems facing the medical community of Georgia. Sincerely, Jimmy Carter, Governor of Georgia."

President Eldridge then introduced to the Banquet audience Dr. C. L. Ayers, of Toccoa, Georgia, a 1902 medical school graduate.

President Eldridge then acknowledged MAG's vital and continuing interest in Georgia's two outstanding medical schools. As evidence of that interest, he then presented unrestricted grant monies raised by contributions from physicians and Woman's Auxiliaries made to the American Medical Association Education and Research Foundation during the year 1971 as follows:

Dr. Chris Fordham, Dean of the Medical College of Georgia, received from President Eldridge a check in the amount of \$5,980.28.

Dr. Fleming Jolley, of Emory University School of Medicine, received a check from President Eldridge in the amount of \$5,582.88 for Emory University School of Medicine.

Certificates of Appreciation

President Eldridge then stated that the Medical Association of Georgia wished to present a Certificate of Appreciation to an individual who would be unable to be present for the awards ceremony the following day. President Eldridge then presented the Certificate of Appreciation to the President of the Woman's Auxiliary to the Medical Association of Georgia, Mrs. Myrtle Smith, of Columbus, and expressed appreciation to her for her efforts and activities during the past year.

Scientific Exhibits Prizes

Dr. John N. McClure, Atlanta, Chairman of the MAG Committee on Scientific Exhibits, was then called on by President Eldridge to announce the winners in the 1971 Scientific Exhibit as follows:

First Place—"Coronary Cinearteriography in the Diagnosis of Arteriosclerotic Heart Disease"

Arnoldo Fiedotin, M.D., *Atlanta*

Second Place—"Rapid Diagnosis by Cytological Techniques"

John T. Godwin, M.D., *Atlanta*

Third Place—"The Management of Neonatal Intestinal Atresia"

Gerald T. Zwiren, M.D., and H. Gibbs Andrews, M.D., *Atlanta*

Golf Prizes

President Eldridge then announced that some excellent scores had been carded by those participating in the Golf Tournament and called on Dr. E. J. Waits to announce the prize winners. Dr. Waits informed the group that 39 participants had made the Golf Tournament a most interesting and successful one and announced the winners as follows:

Low Gross—Harry Soder, M.D.

Runner-up Low Gross—Steve Mulherin, M.D.

Low Net—Alton Hallum, M.D.

Runner-up Low Net—Ed Waits, M.D.

Longest Drive—Steve Mulherin, M.D.

Close-up No. 6—Parry Soder, M.D.

Close-up No. 13—P. Hearn, M.D.

Tennis Prizes

Dr. Eldridge then called on Dr. Neal H. Newsom, Chairman of the Tennis Tournament, to present the winners in that tournament as follows:

Singles Winner—Bill Moretz, M.D.

Singles Runner-up—Ben Okel, M.D.

Doubles Winners—Ronald Galloway, M.D., and Bill Moretz, M.D.

Doubles Runners-up—Dick Margeson, M.D., and Newton Turk, M.D.

Over 45—Bill Moretz, M.D.

Art Exhibit Prizes

President Eldridge then recognized Mrs. Pano Lamis, of Atlanta, Chairman of the Art Exhibits for 1971, who thanked the Art Exhibit Committee and judges, and then announced the Art Exhibit Prize winners as follows:

First Prize—Dr. Philip Nippert

Second Prize—Dr. Alex P. Jones

Third Prize—Scott McGinnis (son of Dr. and Mrs. Lamar McGinnis)

Honorable Mention—Dr. Frederick Hardin, Dr. Eric Kahn, Mrs. Eric Kahn, Mrs. Ann Gower, Mrs. Maria H. Hubert, and Dr. Calvin Sandison

Medical Mile

President Eldridge then recognized Dr. Carson Burgsteiner, Chairman of the 1971 Medical Mile,

who announced that Dr. Richard L. Benson, of Douglas, had won the 1971 Medical Mile, run this year for the first time on an indoor track, in the time of six minutes thirteen seconds.

Civic Endeavor Award

President Eldridge reminded the members present that the 1968 House of Delegates had created the Civic Endeavor Award to recognize outstanding public service and participation in civic activities. He stated that this coveted award is presented to the individual selected by the secret Committee on Awards from nominees submitted by component County Medical Societies. Dr. Eldridge announced that the 1971 recipient was Dr. A. J. Kravtin, of Columbus.

Hardman Cup

President Eldridge then related the history of the Hardman Cup Award, which was established in May, 1931, by Governor Lamartine Hardman, M.D., to recognize an outstanding discovery in medicine and surgery, or the solving of some particular problem in the field of public health. President Eldridge advised the members present that there had been only 25 recipients of the Hardman Cup since 1931, but that the secret committee making the awards selections had chosen a recipient for 1971. Dr. Eldridge then announced that the winner of the Hardman Cup Award was Dr. Curtis G. Hames, of Claxton.

President Eldridge then expressed his appreciation to the Medical Association of Georgia for the opportunity of serving as its President for 1970-71, and asked that President-Elect, W. C. Mitchell, join him at the podium. Dr. Eldridge then recognized the fact that Dr. Mitchell would be installed with the other officers of the Medical Association of Georgia at the General Business Session on Sunday, May 16, but stated that he wished to symbolically pass the gavel of office to Dr. Mitchell as incoming President.

Dr. Mitchell received the gavel of office and expressed his appreciation to the Medical Association of Georgia for their trust, demonstrated by his election as President-Elect.

Dr. Mitchell then turned the meeting over to the Master of Ceremonies, Dr. Eldridge, who introduced the entertainment for the evening, Dr. James T. Brown and the other Singing Doctors of Greene County Medical Society, Missouri. Dr. Eldridge pointed out that the Singing Doctors had established a non-profit foundation offering scholarship aid to medical students.

MAG General Session (Second General Business Session)

117th Annual Session of the Medical Association of Georgia

Sunday, May 16, 1971

THE SECOND GENERAL SESSION of the 117th Annual Session of the Medical Association of Georgia was called to order Sunday, May 16, 1971, by President F. G. Eldridge, of Valdosta, at 9:00 a.m., in the North and Center Ballrooms, Marriott Motor Hotel, Atlanta.

President Eldridge opened the meeting with the traditional reading of the Memorial List of those colleagues who had died since the 1970 Annual Session as follows:

Charles G. Boland, Sr., Atlanta, January 7, 1971
J. C. Brim, Pelham, April 22, 1971
J. B. Brown, Baxley, August 30, 1970
Taylor S. Burgess, Atlanta, October 9, 1970
John F. Busch, Marietta, May 6, 1970
Howard L. Cheshire, Thomasville, January 7, 1971
E. D. Colvin, Atlanta, February 27, 1971
Leo P. Daly, Atlanta, February 6, 1971
Ben E. Daniel, Jacksonville, Florida, July 13, 1970
Harold T. Dillon, Atlanta, November 5, 1970
Frank L. Eskridge, Jr., W. Panama City, Florida, October 4, 1970
T. J. Ferrell, Waycross, May 29, 1970
Roy L. Gibson, Columbus, February 19, 1971
R. C. Goolsby, Macon, April 6, 1971
Louie H. Griffin, Sr., Claxton, January 10, 1971
E. R. Harris, Winder, September 3, 1969
S. P. Holland, Blakely
Anne Hopkins, Savannah, August 31, 1970
C. S. Jernigan, Sparta
Robert W. Johnson, Boston, July 14, 1970
Clarence L. Laws, Atlanta, November 16, 1970
E. A. Lessem, Decatur, June 7, 1970
Malcolm D. Lockhart, Ellenwood, December 23, 1970
Ralph B. McCord, Rome, June 24, 1970
C. K. McLaughlin, Macon, June 16, 1970
Bert H. Malone, Brunswick, December 15, 1970
Warren B. Matthews, Marietta, May 7, 1971
S. L. Morris, Augusta, December 1, 1970
James L. Nalley, College Park, March 5, 1971
Emory G. Newsome, Sandersville, September 11, 1970
Thomas F. O'Donald, Bainbridge, December 22, 1970
Wyatt B. Pauncey, Dublin, June 11, 1970
Mark P. Pentecost, Sr., Atlanta, October 10, 1970
L. W. Pierce, Waycross, June 28, 1970
Ernest E. Proctor, Jr., Newnan, November 18, 1970
Frank E. Randolph, Augusta, January 29, 1971
C. L. Ridley, Sr., Macon, October 4, 1970
R. L. Rhodes, Augusta, February 16, 1971
R. W. Richardson, Macon, April 9, 1971
Jacob Rubin, Savannah, November 25, 1970

William Vernon Skiles, Atlanta, July 3, 1970
Robert L. Robinson, Atlanta, March 27, 1971
Trammell Starr, Dalton, March 12, 1971
John B. Thompson, Columbus, July 6, 1970
O. R. Thompson, Macon
Rosina Vicinzi, Marietta, May 7, 1971
C. M. Warnock, Atlanta, July 23, 1970
Harry A. Wasden, Quitman, February 24, 1971
William C. Waters, Jr., Atlanta, May 4, 1971
Charles H. Watson, Augusta, April 2, 1971
Hiram J. Williams, Cordele, January 28, 1971

President Eldridge then recognized the Reverend Thomas A. Whiting, Pastor of the Peachtree Road United Methodist Church, in Atlanta, who assisted the House of Delegates and General Assembly in observance of the Sabbath Day by some appropriate and thoughtful remarks.

Certificates of Appreciation

President Eldridge then recognized the MAG Secretary, John Rhodes Haverty, M.D., to present MAG Certificates of Appreciation to individuals deserving of special recognition for their contributions to medicine as follows:

F. G. Eldridge, M.D., as MAG President 1970-1971; F. William Dowda, M.D., as MAG First Vice President 1970-1971; Eugene L. Griffin, M.D., as Chairman, MAG Maternal and Infant Welfare Committee; John R. McCain, M.D., as Chairman, MAG Medical Review and Negotiating Committee; Virgil B. Williams, M.D., as Chairman, Disaster Medical Care Committee 1962-1970; W. C. Mitchell, M.D., as Chairman, Committee on Woman's Auxiliary 1967-1970 and Cobb County Councilor 1966-1970; Charles Eberhart, M.D., as Chairman, MAG Nursing Liaison Committee 1966-1971; J. Rhodes Haverty, M.D., as Chairman, MAG Medical Education Committee 1967-1970; Ernest E. Proctor, M.D., as Sixth District Councilor 1968-1970; Roy L. Gibson, M.D., as Muscogee County Councilor 1968-1971 and member, State Board of Health 1966-1971; Representative Clayton Brown, Jr., for outstanding service in the field of Health Legislation; Neal Yeomans, M.D., as Alternate AMA Delegate; George Alexander, M.D., as Chairman of MAG Committee on Constitution and Bylaws and S. William Clark, M.D., Chairman, Committee on Woman's Auxiliary to MAG 1970-1971.

President Eldridge recognized MAG Second Vice President, Henry D. Scoggins, who presented Life



Rep. Clayton Brown, Jr., receives a Certificate of Appreciation from Dr. Rogers.

Membership Certificates in the form of special gold membership cards to MAG Life Members as follows:

George H. Alexander, *Forsyth*; C. H. Bryant, *Comer*; V. L. Bryant, *Wadley*; W. W. Chrisman, *Macon*; O. D. Gilliam, *Columbus*; Guy C. Hewell, *Atlanta*; J. H. Kite, *Atlanta*; H. G. Mosley, *Atlanta*; E. K. Mann, *Columbus*; B. L. Shackelford, *Atlanta*; H. F. Sharpley, Jr., *Savannah* and Raymond Suarez, *Macon*.

Fifty Year Awards

President Eldridge then recognized MAG First Vice President, F. William Dowda, who presented Fifty Year Certificates to members who were graduated from medical school and licensed to practice 50 years ago:

James F. Adams, Sr., *Montezuma*; Wallace L. Bazemore, *Macon*; John C. Blalock, *Atlanta*; P. O. Chaudron, *Cedartown*; Herbert M. Edge, *Blairsville*; Charles W. Harwell, *Moultrie*; William F. Jenkins, *Columbus*; F. Lansing Lee, *Augusta*; John M. Monfort, *Hilton Head, S.C.*; Julian K. Quattlebaum, *Savannah*; James W. Reid, *Thomasville*; Harry W. Ridley, *Sea Island*; Bernard L. Shackelford, *Atlanta* and Warner L. Thomson, *Atlanta*.

GaMPAC Awards

Dr. Luther M. Vinton, of Decatur, Chairman of the Georgia Medical Political Action Committee, was then recognized by President Eldridge for the purpose of awarding plaques in three categories of outstanding contributions to the PAC movement:

Highest Percentage of County Membership—Alamaha Medical Society

Highest Percentage of District Membership—Fourth Congressional District

Highest Total Dollar Contribution—DeKalb County Medical Society

Distinguished Service Award

President Eldridge then stated that the highest honor that the Medical Association of Georgia could bestow in recognition of service to MAG was the Distinguished Service Award. He further explained that this was not necessarily an annual award, but was given only when some member deserved such by serving the Association far above and beyond the call of duty. Dr. Eldridge then announced that a secret committee had selected as the 1971 recipient of the Distinguished Service Award, Dr. John Kirk Train, Jr., of Savannah, and asked that the members present give Dr. Train a rising vote of applause as he came forward to receive the Award.

Future Annual Session Sites

President Eldridge then recognized Dr. Preston D. Ellington, Chairman of the MAG Committee on Annual Session, for announcement of future meeting sites.

Dr. Ellington announced that invitations had been received from local medical societies for meetings in 1976 and 1977 and reviewed the complete calendar of future meeting sites as follows:

1972—Macon
1973—Augusta
1974—Savannah
1975—Atlanta
1976—Jekyll Island
1977—Macon

At this point President Eldridge announced that the Second General Session was now recessed and turned the gavel over to Speaker of the MAG House of Delegates, Dr. Harrison L. Rogers, who convened the Second Session of the MAG House of Delegates in conjunction with the 117th Annual Session.



John R. McCain, M.D., receives a Certificate of Appreciation.

Second Session, House of Delegates

Sunday, May 16, 1971

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia, held in conjunction with the 117th Annual Session of the Association, was called to order by Speaker Harrison L. Rogers, Jr., M.D., at 9:45 a.m., in the North and Center Ballrooms, Marriott Motor Hotel, Atlanta, Ga., on Sunday, May 16, 1971.

Speaker Rogers called for the report on attendance from the Chairman of the Committee on Credentials, Dr. Bill Purcell, who reported that over 40 Delegates were present and accounted for and that since 40 members of the House constituted a quorum, business could proceed. Speaker Rogers declared a quorum present and the House of Delegates duly in Session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

Attendance

In a compilation of attendance taken from the official roll, 39 county medical societies were represented by their duly elected Delegates or Alternates. Of a total of 170 authorized Delegates by their respective medical societies, the official roll showed 117 Delegates present at this Second Session:

BALDWIN: Samuel Goodrich; BEN HILL-IRWIN: Ralph Roberts; BIBB: A. L. Mayes, Jr., Jack Menendez, and B. B. Sanders, Jr.; OGEECHEE RIVER: Charles Richardson; CARROLL-DOUGLAS-HARALSON: J. Larry Boss; GEORGIA MEDICAL: Carson B. Burgstiner, J. P. Evans, J. Robert Logan, Joseph A. Mulherin, and A. F. Williams; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald Branyon, F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, Richard W. Kimmerling, James H. Manning, Robert D. May, Charles J. Rey, Donald R. Rooney, and Webster Sherrer; COWETA: Robert J. Jarrell; DEKALB: Philip E. Christopher, John Heard, Philip M. Jardina, William J. Rawls, George W. Statham, O. W. Stubbs, Knox Walker, and Charles B. Watkins; DOUGHERTY: J. Daniel Bateman, Charles D. Hollis, Jr., and Robert D. Waller; EMANUEL: Robert J. Moye; FLOYD: W. H. Lucas; FULTON: Earl L. Alderman, John S. Atwater, Norman Berry, Tully T. Blalock, James N. Brawner, III, Spencer Brewer, Jr., F. William Dowda, William Edwards, Edwin C. Evans, Henry Finch, G. Lester Forbes, Joseph Girardeau, Irving L. Greenberg, Alton V. Hallum, Jr., L. Harvey Hamff, J. Harold Harrison, John Rhodes Haverty, William S. Huger, Jr., Fleming L. Jolley, James A. Kaufmann, William D. Logan, J. G. McDaniel, William McDougall, William W. Moore, Jr., W. P.

Nicholson, Jr., Edwin C. Pound, Harold S. Ramos, Albert A. Rayle, Jr., John K. Schellack, Lee R. Shelton, Hugh S. Thompson, Thomas Tidmore, Charles E. Todd, L. N. Turk, J. Frank Walker, William C. Waters, Robert E. Wells, Frank Wilson, and Joseph S. Wilson; GLYNN: C. S. Britt; GORDON: R. D. Walter; HABERSHAM: Thomas N. Lumsden; HALL: Billy S. Hardman, John Reed, and C. W. Whitworth; PEACH BELT: Carl L. Crawford; JACKSON-BANKS: E. W. Holloway, Jr.; LAURENS: W. M. Watkins; McDUFFIE: Thomas E. Averitt; MUSCOGEE: Henry H. Boyter, Bob Maughon, Jack A. Raines, and Luther J. Smith, II; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Clyde A. Burgamy, Preston D. Ellington, William A. Fuller, Ronald F. Galloway, Menard Ihnen, Julius T. Johnson, William H. Moretz, Stuart Prather, Jr., Henry D. Scoggins, Walter L. Sheppard, and Cecil A. White, Jr.; SPALDING: Alex P. Jones and James M. Skinner; SOUTH GEORGIA: Joe C. Stubbs; STEPHENS: Irving D. Hellenga and Frank R. Miller; TIFT: R. P. Wight, Jr.; TROUP: Charles T. Cowart; UPSON: T. A. Sappington; WARE: S. W. Clark and Floyd E. Davis; WAYNE: Ollie O. McGahee, Jr.; WHITFIELD: James J. Oosterhoudt; WORTH: H. G. Davis; SAMA—MEDICAL COLLEGE OF GEORGIA: H. Stanley Guest.

Election of Officers

Speaker Rogers then announced that at this time the House would elect the Officers for the coming year and two Delegates and Alternates to the American Medical Association for the term January 1, 1972, to December 31, 1973. Since there were no contested races this year, Speaker Rogers read the list of duly nominated candidates as follows:

President-Elect—F. William Dowda, M.D., *Atlanta*
Second Vice President—Braswell E. Collins, M.D., *Macon*
Speaker of the House of Delegates—Harrison L. Rogers, Jr., M.D., *Atlanta*
Vice Speaker of the House of Delegates—Preston D. Ellington, M.D., *Augusta*
AMA Delegate—J. W. Chambers, M.D., *LaGrange*
AMA Delegate—John S. Atwater, M.D., *Atlanta*
AMA Alternate Delegate—F. G. Eldridge, M.D., *Valdosta*
AMA Alternate Delegate—Henry S. Jennings, M.D., *Gainesville*

On motion duly made and seconded, the slate of Officers, Delegates, and Alternates as read was unanimously elected.

Speaker Rogers then called for reports from the Reference Committee Chairmen. Speaker Rogers explained that the matter of business as introduced would be considered the motion of the floor, and

that if no discussion or dissent followed each portion of the Reference Committee Report, he would rule the item adopted as introduced. However, in the event that a Reference Committee amended a report or presented a substitute, the House should consider it the motion before the House. Speaker Rogers explained that the Chair would rule each item adopted pending final vote on the entire report of each Reference Committee.

Report of Reference Committee A

Rupert H. Bramblett, M.D., Chairman

Chairman Bramblett reported to the House that reports and resolutions referred to Reference Committee A had been considered by the Committee which met at 9:00 a.m., in the Hickory Hill Suite, Marriott Motor Hotel, Atlanta, Ga., on May 15, 1971. Members of the Committee present included: Rupert H. Bramblett, M.D., Cumming, Chairman; Jack A. Raines, M.D., Columbus, Vice Chairman; William Perrin Nicolson, III, M.D., Atlanta; Samuel M. Goodrich, M.D., Milledgeville; R. D. Roberts, M.D., Fitzgerald; and John P. Heard, M.D., Decatur.

Speaker of the House of Delegates

HARRISON L. ROGERS, M.D., Atlanta

As reviewed in previous reports to the Association, mechanisms for the operation of the House of Delegates have been refined and simplified. I believe these changes have worked to the benefit of both the House of Delegates and to the entire Medical Association of Georgia. Last year for the first time the officers of the Association were elected by the House of Delegates.

In addition to the smoother operation of the House of Delegates, I believe that information about the actions of the House is being disseminated somewhat better than in the past. Specifically that portion of the annual County Society Officers Meeting dealing with the indoctrination of new members was well received by those in attendance, though their number fell short of the anticipated attendance.

I am pleased to report that an ever growing number of County Societies are meeting in caucus prior to the Annual Session to review and deliberate all the measures to be considered by the House of Delegates. This homework prior to the Annual Session is of inestimable value to the Delegates who will represent their societies in May. In addition to which, the guidance that these informed Delegates are able to bring to the House and its Reference Committees is most valuable. Communication and thereby education between all members of the MAG, the Council and the Executive Committee of MAG continues to be an important problem.

RECOMMENDATIONS

(1) That indoctrination of new members continue to be a part of the Annual County Society Officers Conference and that consideration be given to making attendance at such meetings a prerequisite for active MAG membership.

(2) That Council working with the Publications Committee continue its effort to improve communications between all our members.

(3) That Section 8 of Chapter III of the Bylaws be deleted and that the smooth operation of the House of Delegates and its Reference Committees is continued by referring to Reference Committees only resolutions and reports containing recommendations or those on which referral is requested for the purpose of debate.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee strongly endorses the principle and intent of Recommendation (1) and recommends that the matter be referred to the Constitution and Bylaws Committee for study and implementation.

Your reference committee recommends approval of Recommendation (2), that membership communication be improved. With regard to Recommendation (3), your reference committee, in an effort to assure adequate consideration of all matters of business before the House of Delegates, recommends that the Constitution and Bylaws Committee be directed to consider amendments to Chapter III, Section 8, to incorporate the following intents:

(1) That all resolutions shall be referred to the appropriate reference committees before action is taken by the House of Delegates.

(2) Reports containing information without recommendations may be presented to the assembled House of Delegates without referral to a reference committee at the discretion of the Speaker, provided their presentation be made at the First Session of each meeting of the House of Delegates in order that any delegate may request the referral of such report to a reference committee for debate.

(3) The Speaker of the House of Delegates shall honor such request by the immediate assignment of the report in question to the appropriate reference committee.

HOUSE OF DELEGATES ACTION—Delegate Menard Ihnen, Richmond County Medical Society, moved to amend the Reference Committee report by substituting the original recommendation altered to read as follows:

“1) That indoctrination of new members continue to be a part of the annual County Society Officers’ Conference and that each County Society encourage new members to attend.”

This amendment was adopted on a voice vote.

The House then adopted the report of the Speaker of the House of Delegates with the changes recommended by the Reference Committee, and as amended by the House.

Public Relations Committee

J. WATTS LIPSCOMB, M.D., Chairman

The primary activity of this Committee has been the planning of the Annual County Society Leadership and New Member Indoctrination Conference, which was held on February 6 and 7, 1971. From all comments, this conference was quite well received.

For the first time this year, as a directive from the House of Delegates, an indoctrination course for new members was held. Much thought and effort was utilized in planning the program format for the new members after interest was expressed in such a program, and this also seemed to be well accepted, but attendance was not as anticipated.

It is the understanding of the Chairman that the name of the Committee was changed from the Public Service Committee to the Public Relations Committee with the view to this Committee's becoming more involved in general public relations in the future. However, it was impossible to obtain enough active participation from the Committee to accomplish this end.

RECOMMENDATIONS

(1) That the Officers and New Member Conference be continued as an annual activity of this committee.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with commendation and recommends an additional recommendation (2) as follows:

That each County Medical Society consider electing their County Society officers before the end of each calendar year and that they be installed into office following the MAG Annual Session in order that they can participate in the County Society Officers Leadership Conference early in the year before taking office.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Public Relations with the amendment recommended by the Reference Committee.

Cobb County Medical Society Councilor

W. C. MITCHELL, M.D., *Smyrna*

The Cobb County Medical Society continued to gain in membership this year, from 155 to 168 members by December 31, 1970. As of this writing, the membership is 175, which is still far too few for the rapid increase in population of this area.

Dr. Remer Clark, the Vice Councilor, who is to take my place as Councilor, continues to be of great help. He has attended all Council meetings, keeping abreast of developments; has helped in making reports to the Cobb County Medical Society; and he was instrumental in getting in most of the delinquent assessments.

Since his election in December of 1970, Dr. Charles Underwood, who will be the Vice Councilor, has been present at these meetings also.

I have attended all the Council meetings as well as the meetings for all the general committees, and the leadership conference meeting. For the second year, I served a day as Doctor of the Day at the Capitol during the meeting of the General Assembly. I have thoroughly enjoyed all the meetings attended and have considered it a real privilege to represent Cobb County to the Medical Association of Georgia.

The Cobb County Medical Society continues to meet every other month and the meetings are a combined social and scientific affair, and the attendance continues to be unusually good. The month that the society does not meet, the executive board meets and carries on the necessary business. Dr. Clark, the Vice Councilor, and I have attended these meetings and have given reports to the group from the Council.

The Cobb County Medical Society, along with the Cobb Judicial Circuit Bar Association, the Marietta-Smyrna Ministerial Association, and Kennesaw Junior College will again this year conduct its annual Symposium. Symposium '71 has for its theme "America vs. America—The Revolution in Values." It will be held

April 29 and 30 at Kennesaw Junior College. Again the program will be centered around five outstanding speakers, including Dr. Margaret Mead and Mr. Justice Tom C. Clark. The public is invited, and if the five previous Symposiums are any indication, it is sure to be well received, with exceptionally good attendance.

Again let me say it has been an honor and a privilege to serve on the Council as the representative of Cobb County, and I'm sure I may say the same for the Vice Councilor, Dr. Remer Clark, who is now the Councilor-Elect.

RECOMMENDATIONS

Some method be devised to better communicate with our members and some motivation found to get these members to read their state Medical Journals and other literature sent to them, in order to get them involved.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries Cobb	Members December 31, 1970		Members December 31, 1969	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
F. Norman Bowles, Jr. Austell	168	159	155	145

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Cobb County Medical Society Councilor as recommended by the Reference Committee.

Georgia Regional Medical Program

M. C. ADAIR, M.D., *Coordinator*

In August, 1970, I succeeded George Alexander as Coordinator of the Georgia Regional Medical Program. He, in turn, followed J. H. Chambers, who had been the original coordinator. Thanks to the efforts of these two men, my work, I am sure, has been easier. The Medical Association of Georgia owes these fine gentlemen a debt of gratitude.

Not too many publicly financed health programs are as medically directed and oriented as our GRMP. We need to continue to show the state and the nation that we can do this type of endeavor.

In Georgia, the Program is responsible for the expenditure of over 1.85 million dollars for public funds annually. Of course accounting and evaluation form important activities to assure that the project funds are expended purposefully.

I note that the representatives of the Medical Association of Georgia to the Regional Advisory Group have not been attending the sessions as well as they should. Since organized medicine (MAG) is the fiscal agent responsible, it is important that our members participate in the policy making activities.

Many worthy elements are on the drawing board. Of interest is the fact that GRMP, at the direction of the Administration, is broadening its interests beyond heart disease, cancer, and stroke. Improving the delivery of health care will receive increasing attention in the future. Since MAG is committed to the improvement of health care delivery whenever possible, we should welcome this activity.

As this is being written, I notice in the *AMA News* that the national Regional Medical Program budget for this fiscal year has been slashed \$34.5 million and that the budget authority being sought for FY '72 contains only \$52.5 million in new funds. Obviously some pruning and redoing will be necessary in Georgia.

RECOMMENDATIONS

(1) That MAG continue its participation in RMP in a meaningful fashion.

(2) That MAG members on the Regional Advisory Group more actively participate by attending the meetings.

(3) That MAG protest the reduction of the FY '71 RMP budget by \$34.5 million and offer the following resolution through proper channels to the AMA.

RESOLUTION

WHEREAS, the Medical Association of Georgia acts as the fiscally responsible organization for the receipt of federal funds to operate the Georgia Regional Medical Program; and

WHEREAS, the Georgia Regional Medical Program has undertaken or is planning to undertake many excellent programs and activities to help the physicians of Georgia improve the health care of the people of Georgia; and

WHEREAS, the physicians of Georgia individually and collectively are involved deeply in the activities of the Georgia Regional Medical Program; and

WHEREAS, the Medical Association of Georgia is totally committed to the continuation and expansion of the Georgia Regional Medical Program; and

WHEREAS, it appears that the majority of state medical associations are involved and committed to continued development of Regional Medical Programs; and

WHEREAS, the 1972 Presidential Budget for Regional Medical Programs has been severely reduced; and

WHEREAS, the Regional Medical Programs are being asked to increase their scope of activities with severely reduced budgets;

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia urges the AMA House of Delegates to charge the Board of Trustees and Staff to exhaust all possibilities in attempting to persuade the Department of Health, Education and Welfare to restore the budget reductions for Regional Medical Programs; and

FURTHER BE IT RESOLVED, that AMA through appropriate channels express to Secretary of HEW Richardson the high degree of commitment that the medical profession has for continued development of Regional Medical Programs.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with commendation and recommends that copies of the resolution contained in this report be sent to Georgia's two U.S. Senators and 10 Congressmen.

HOUSE OF DELEGATES ACTION—Adopted the report of the Coordinator, Georgia Regional Medical Program, with the amendment recommended by the Reference Committee.

Alternate Delegate to the AMA

F. W. DOWDA, M.D., *Atlanta*

Again it has been a gratifying experience to serve with such fine men as I have had the opportunity of serving with on the AMA delegation. It is obvious and apparent that we are going to need all the unified support from our members that we are able to obtain in order to effect adequate programs for medicine over the next several decades.

RECOMMENDATIONS

There are several areas that are particular trouble spots, that have been trouble spots in the past indeed, and do remain so for the present and the future, and I would like to recommend that we appoint Ad Hoc Committees. These would be appointed by the President with the approval of the Council of the Medical Association of Georgia to study increasing the liaison and activity of students in our Association and the liaison and activity of the specialty groups in our Association, and that a report be brought back to Council by March in order that an opinion by Council may be formulated and presented to the Medical Association of Georgia at this House of Delegates meeting next year.

I recommend that MAG adopt the Ad Hoc Committee system described above.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the report with deletion of the recommendation and substitution in lieu thereof the following: that the President of the Medical Association of Georgia appoint three Ad-Hoc Committees to accomplish the following:

(1) To promote better liaison and involvement with specialty societies.

(2) To promote better liaison and involvement with the students of our medical schools, and

(3) To study our committee structure.

These Ad-Hoc Committees, if appointed, should report to Council by March, 1972, with their recommendations.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA Alternate Delegate as amended by the Reference Committee.

Insurance and Economics Committee

WILLIAM W. MOORE, JR., M.D., *Chairman*

It is a pleasure to submit the following report of the activities of the Committee on Insurance and Economics.

The Committee held meetings with representatives of Insurance Specialists, Inc., regarding the removal of the implied endorsement of MAG from promotional materials used by Insurance Specialists, Inc.

Continuing education costs in hospital reimbursement formulas was a question presented to the Committee during the year, and in the subsequent investigation, the Committee learned and then reported to the Committee on Medical Education that we were unable to identify any carriers in Georgia that did not include educational expenses in their reimbursements.

Plans for business overhead protection insurance were investigated by the Committee, and it was



F. W. Dowda, M.D., Atlanta, addresses the House of Delegates.

learned that the most economical plan could be obtained through the Southern Medical Association.

The Committee has continued to look at the insurance package available to members from the Life of Georgia, and there still exists some doubt as to whether MAG's benefits package is all that it should be through that carrier. The Committee has continued to survey the value of the package being offered to members.

The Committee has maintained its good relationships with carriers, and in particular, the St. Paul Insurance Companies. The Committee initiated and obtained a commitment for a re-study of risk categories in professional liability plans from the National Insurance Rating Board. Lengthy negotiations with company officials produced the following rates for MAG's professional liability plan effective May 1, 1971. Comparative figures for Georgia set by the National Insurance Rating Board applicable to other companies is shown to illustrate the comparative value of MAG's plan:

	1971-72 Rates 100/300	1971 Standard Bureau 100/300
I. Physicians, No Surgery— Dermatologists, Psychiatrists, Pathologists, Radiologists, Pediatricians 212	212	275
(Double rate for Psychiatrists and Radiologists using therapy)		
II. Physicians—Minor Surgery 284	284	481
III. Surgeons—Ophthalmologists, Proctologists 665	665	1,043
IV. Surgeons—General, Thoracic, Cardiac, Urologic, Otolaryngologic, Vascular 779	779	1,391
(No Plastic)		
V. Surgeons—Anesthesiologists, Orthopedists, Neurosurgeons, Otolaryngologists, Obstetricians, Gynecologists, Plastic Surgeons . 873	873	1,739

The Committee served as the catalyst for revision of County Society Bylaws in Fulton and Richmond to pro-

vide for student memberships from Georgia's two medical schools.

Uniform claim forms has been the continuing effort of the Committee this year, and we would appear to be on the threshold of arranging a combining of the claim forms of the Blue Plans and private commercial companies. The other two categories, that is, Workman's Compensation and Government Third Parties, would seem to have insurmountable problems in coordinating their claim forms with private insurance and Blue Plans.

A review of all proposed legislation with regard to liability claims was undertaken with the assistance of the Liaison Committees of MAG to the Georgia Bar Association and the Georgia Bar Association's Liaison Committee. This review, however, failed to uncover any legislative approaches potentially beneficial.

The Committee initiated a recommendation later adopted by the Executive Committee of Council and the Council to adopt a resolution asking both Blue Shield Plans in Georgia to pursue actively a more widespread intrastate sale of their usual and customary fee contracts.

A major accomplishment of the Committee this year has been the development of a comprehensive Blue Cross-Blue Shield Plan including major medical available to the entire MAG membership, families and employees. The unique features of this Plan include usual and customary fee payment basis and Foundation processing of claims. This Plan has been endorsed by the Council and added to the membership benefits package. The plan becomes effective when 50 per cent of MAG membership subscribes.

The Committee held a special meeting with representatives of labor, management, and insurance carriers for preliminary discussions regarding the establishment of a comprehensive prepaid health care plan in Georgia. Continued good liaison with all carriers has been the major ongoing accomplishment of the Committee.

I wish to express my sincere thanks to those Committee members who attended meetings this year and assisted with this important work. The thanks of the Committee also are due Mr. Smith and the Headquarters' staff for their hard work this year.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Insurance and Economics as recommended by the Reference Committee.

**Supplemental Report of the Committee
on Insurance and Economics**

WILLIAM W. MOORE, JR., M.D., *Chairman*

It is a pleasure to announce the changes described below in the Association sponsored program for life and disability income insurance underwritten by Life of Georgia. These changes have been designed to make membership in the plan more attractive for younger doctors when they join MAG. With these changes, participation in the program should be substantially increased, resulting in savings to all members over the long range.

The rate reductions described below will be effective for new members joining the plan on or after June 1,

1971. For members presently enrolled, the reduced rates will be effective November 15, 1971.

Disability income rates have been reduced under age 45. Semi-annual premiums for \$250 of weekly income, with lifetime benefits for accident and sickness benefits to 65, 30-day elimination period, are compared below.

Age	Old Rates	New Rates
Under 30	\$207.20	\$118.00
30-34	207.20	132.00
35-39	258.85	155.00
40-44	258.85	191.00
45 and up	No Change	No Change

These lifetime accident and sickness to 65 benefits are available with coverage starting on the 1st day for accident and the 8th day for sickness, with a 31-day elimination period on both, as illustrated above, or with a 90- or 180-day elimination period. The longer elimination periods carry lower premiums.

Those members presently covered for the old 2-year maximum disability benefits may change to the lifetime accident and sickness to 65 benefits, upon presentation of evidence of health satisfactory to Life of Georgia.

Life and Accident Death and Dismemberment Insurance for *new* members was increased to \$20,000, effective November 15, 1970. Members presently covered for \$10,000 will have the opportunity to increase their coverage to \$20,000, regardless of their health, as of November 15, 1971. Their benefit schedule would then be \$20,000 to age 60, \$10,000 from 60 to 70 and \$6,500 from 70 to 75, with coverage terminating at 75.

Premiums for Life and AD&D have been reduced under age 40. The comparison of semi-annual premiums for \$20,000 is as follows:

Age	Old Rates	New Rates
Under 30	\$40.00	\$24.50
30-34	42.40	27.80
35-39	49.40	42.70
40 and up	No Change	No Change

\$5,000 of Life and AD&D will be available to employees of covered doctors on the same per \$1,000 rate basis.



J. Rhodes Haverty, M.D. and Charles E. Bohler, M.D., at the Annual Banquet.

For the information of members who want to consult their own insurance agent about joining the plan and what disability income elimination period to elect, Life of Georgia will pay a modest first year commission to any agent licensed for life and A&S in Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the supplemental report of the Committee on Insurance and Economics as recommended by the Reference Committee.

Cancer Committee

HOKE WAMMOCK, M.D., *Chairman*

NURSES HANDLING PAP SMEAR PROCEDURE

A letter was received from Mrs. Preston from the Georgia Division of the American Cancer Society in reference to the West Virginia Nurses Association, performing vaginal examinations to determine the progress of labor and taking vaginal smears and cultures for cancer detection. It was learned that Mrs. Dorothy Barfield of the Georgia State Nurses Association had written Dr. Charles Eberhart, Chairman of the MAG Committee on Nursing Liaison, and the action taken by Dr. Eberhart's Committee. The request made by Mrs. Barfield was that practicing registered nurses or others under her supervision could collect Pap smears for cervical cancer detection. The nurse should have had competent instructions and periodic supervision in this technique, to be performed only upon the order of a physician licensed to practice medicine. It was suggested that written criteria be established in the Health Care Agency by a committee composed of representatives from the medical staff, nursing department and agency administration and that the document must contain the statement granting the permission for a qualified nurse or others under her supervision to take cervical cancer detection smears and outlining a special preparation media, to be qualified to perform the procedure.

Dr. Charles Eberhart's reply to Mrs. Barfield's request was as follows: "With regard to the position statement of the GSNA on cervical cancer detection screening by registered nurses licensed to practice in the State of Georgia, the Nursing Liaison Committee reviewed the statement as submitted by GSNA. The Committee was in favor of this; however, the general feeling was that a complete history and physical, including laboratory studies, is best. But in the absence of these, having a Pap smear taken under any circumstances is good but should not replace the pelvic examination. Some type of instructions should be given to the nurses who will be doing the Pap smear in proportion to their experience."

The Committee on Cancer reviewed this and felt that it could not endorse an overall policy that is to be a statewide procedure for nurses to do pelvic examination and Pap smears. It would have to depend upon the local situation, that is the medical staff, the local society, and others concerned. Therefore, this is purely and simply a local matter. We do not adopt this as a statewide policy.



George H. Alexander, M.D.,
recipient of a Certificate of
Appreciation for his work
as Chairman, Committee on
Constitution and Bylaws.

NEWSLETTER

The Committee reviewed in depth the cancer activities in the State of Georgia and the multiplicity of agencies participating in cancer activities and wish to commend all of those who are carrying out such noble work. Again the Committee points out the urgent need for some means of coordinating these activities and also for informing the members of the Medical Association of Georgia of the activities that are going on in cancer control. It would be most helpful, and it is recommended that all the participating agencies in cancer control forward their information to the Committee on Cancer of MAG. This could be put in the form of a Newsletter to be sent out from time to time as to what has been accomplished and what is planned for the future.

RECOMMENDATION

It is recommended that a Newsletter by the Committee on Cancer be sent out at least four times a year.

NATIONAL CANCER AUTHORITY

There is a Bill before Congress, S-34, better known as the "Conquest of Cancer Act," which would establish a National Concentrated Program of Research Against Cancer. This Bill has been endorsed by three past presidents of the American Cancer Society who have testified before the Congress to this effect. In 1935 the Congress enacted into Law the National Cancer Act and the National Institutes of Health who have been carrying on research and funding of research projects in institutions throughout the United States and also providing trainee grants in cancer. Thus in essence, there will be two authorities dealing with cancer research. The National Cancer Institute and the National Institutes of Health have served the nation well in Cancer Research and Cancer Control, even though it is a Federal Agency. The new Bill, S-34, will create another body to supervise cancer research and cancer control and has been classified or designated as being an aliquot to the Manhattan Project or the Nassar Project to determine the cause and the cure of cancer in as short a period of time as possible. Officers of the American Medical Association have testified before the Congress stating their position that they are in favor of cancer research but do not wish to see the funds placed into the hands of a new body or group. The Georgia Division of the American Cancer Society discussed a proposed publication of information concerning the National Cancer Authority in the *Journal of the Medical Association of Georgia*, and the Cancer Committee endorses the Conquest of Cancer as proposed, but does not care to destroy the work of the last 20 years and

cannot see any point in duplicating the NCI and the NIH with S-34. There are many people who are in favor of a National Cancer Authority, and there are many people who do not favor it. In order to give both sides of the situation, the Committee feels that an article prepared by Dr. Letton on the National Cancer Authority, President-Elect of the American Cancer Society, and the opinion of the American Medical Association prepared by Dr. Russell B. Roth, should be published in the *Journal of MAG*.

RECOMMENDATION

The Committee on Cancer has reviewed the Conquest of Cancer Act and feels that both viewpoints should be presented. Both positions have merits and should have full discussion, and this matter should be referred to the MAG House of Delegates by the Chairman who should be there to defend both positions. Incidentally, the President is in favor of increased research activities in cancer, but does not wish to see the funds taken out of the hands of the NCI and the Institutes of Health.

STATE AID CANCER CONTROL PROGRAM

There has been another drop in the number of patients applying for state aid at tumor registry clinics. Because of this drop, it is difficult for Dr. Palmer's department to get increased funds. Since 1967, the number of patients applying for state aid has decreased by about 50 per cent.

However, the cost of hospital treatment for these patients continues to rise each year, with the average per diem rate being around \$78.00.

RECOMMENDATION

The Cancer Committee recommends that a letter be written to the State Department of Health to the effect that, while there has been a decrease in State Aid applicants, hospital costs have risen, making it difficult for the agency to operate. It is therefore essential that the State Board of Health increase the budget of this agency.

The Committee also feels that there should be a statement to the effect that the reduction in applicants is due to patient utilization of Medicare and Medicaid.

GEORGIA REGIONAL MEDICAL PROGRAM

Mr. Bill Wilkins gave a report on the progress of the Georgia Regional Medical Program in Cancer as follows:

They have applied for support for eight additional cancer facilities, each to include tumor registries. If implemented, this would bring the number of area cancer facilities in Georgia to 20.

The cancer facilities are presently being supported by the Regional Medical Program, which has sustained a significant budget cutback. It seems necessary, therefore, to seek support from other parties. The Chairman, Dr. Wammock, read a letter from the Blue Cross-Blue Shield which stated that they did not feel it was pertinent to try to support cancer clinics at this time. Dr. Wammock, however, will continue to seek support from the Blue programs. Support is doubly essential, as the new guidelines for the Regional Medical Program state that funds should be used now specifically in the establishing of new tumor registries.

The Regional Medical Program does not want to withdraw support from the hospital tumor registries without there being another means of financing, as such a move could cause degeneration of the program, yet the RMP cannot continue to support at the rate they have in the past because of the budget cutbacks. There is a tentative cut-off date of support for the next two to five years.

The Committee feels that, in view of the present economic status of the Federal government, in order to be able to continue the program, it must seek funds from other sources for support of the tumor registries.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends the deletion of the recommendation on lines 19 and 20, page 2, of this report and substitution of the following: It is recommended that information be disseminated in the *MAG Journal* on a time sequence as determined with the *J-MAG* Editor and the Chairman of the Committee on Cancer.

Your reference committee further recommends deletion of recommendations on lines 19 through 26, page 3, of this report and substitutes in lieu thereof the following: that articles presenting opposing views on the Conquest of Cancer Act should be published simultaneously in the *MAG Journal*.

Your reference committee recommends the adoption of the remainder of the report except for the above changes.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Cancer with the amendments recommended by the Reference Committee.

Resolution 71-3

National Annual Opinion Poll

CRAWFORD W. LONG MEDICAL SOCIETY

WHEREAS, the American Medical Association and its component State and County Societies exist only because of their individual physician members; and

WHEREAS, insofar as possible, it is desirable that the National, State and County Societies have the benefit of the broad knowledge and experience of the individual members in directing these organizations; and

WHEREAS, a reasonable method of obtaining these views of the membership would be an annual survey (i.e. a questionnaire poll) on issues and questions deemed of sufficient importance; therefore be it

RESOLVED, that the Medical Association of Georgia request the American Medical Association to institute such an annual solicitation of opinions of its individual members; and further be it

RESOLVED, that this be carried out with the greatest concern for clarity, so as to obtain as true a picture of the physicians' views as human effort permits.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends disapproval of the resolution as presented, but agrees with the intent of the resolution on the need to improve communications. Your reference committee feels that our present channels of communication should be utilized more fully rather than adopt the national opinion poll method.

HOUSE OF DELEGATES ACTION—Disapproved

Resolution 71-3 as recommended by the Reference Committee.

Chairman Bramblett then stated that he wished to thank the members of Reference Committee A and Mr. Carl Bailey for their time and effort, and moved that the Reference Committee report be adopted as a whole. This motion was duly seconded and approved.

Report of Reference Committee B

Ollie O. McGahee, M.D., Chairman

Chairman McGahee reported to the House that the reports and resolutions referred to Reference Committee B had been considered by his Committee, which met at 9:00 a.m., in the Twelve Oaks Suite, Marriott Motor Hotel, Atlanta, on May 15, 1971. Members of the Committee present included: Ollie O. McGahee, M.D., Jesup, Chairman; Henry H. Tift, M.D., Macon, Vice Chairman; Alton F. Williams, M.D., Savannah; H. H. Boyter, M.D., Columbus; and W. C. Waters, M.D., Atlanta.

Secretary

JOHN RHODES HAVERTY, M.D., Atlanta

The Medical Association of Georgia continues to grow: in scope, and in recognition, prestige and leadership among physicians of the nation.

1970 MEMBERSHIP REPORT

Over the past six years, through December 31, 1970, the membership in the MAG has grown 14 per cent for a total of over 450 new members, with an average annual increase of greater than 2 per cent. The breakdown in membership for 1970 is as follows, up from a total of 3,623 for last year:

Active	3,259
DE-1	32
DE-2	51
DE-3	54
DE-4	25
Life	179
Associate	61
Service	55
Honorary	1
Affiliate	1
Total	3,718

GEORGIA REGIONAL MEDICAL PROGRAM

Our Georgia Regional Medical Program has provided functioning programs for physicians and allied health personnel in a variety of areas of involvement. Presently, we have a fine core staff of dedicated workers which is fully funded, and in addition, we have 23 approved and funded projects totalling over \$2,000,000.

In spite of the anticipated decrease in funding for the coming year, our own state program will be cut considerably less than that of our surrounding states and that of the national average. Undoubtedly, this is a reflection of the soundness of our program under the capable leadership of Dr. J. Gordon Barrow, Director of the Georgia Medical Program. Dr. Barrow has been honored this past year with the Chairmanship of the

national group representing directors of all Regional Medical Programs in the nation.

All of us were saddened to have Dr. George Alexander step down after a few months as Coordinator for the Medical Association of Georgia of this important project. Typical of the leadership shown by our physicians in Georgia, however, we were able to come up with a third outstanding individual to step into the able shoes of Dr. Alexander and of Dr. J. W. Chambers, our first Coordinator. Dr. Charles Adair, of Washington, Ga., presently is functioning as Coordinator of this program. Dr. Adair brings with him considerable knowledge of the program, since he has been a member of the Regional Advisory Group from its beginning, as well as full knowledge and interest in the Medical Association of Georgia from his long and dedicated service to the physicians of our state.

The Georgia Regional Medical Program provides an important impetus for upgrading health care in Georgia, and with the guidance of its leaders, and the leaders of the Medical Association, undoubtedly will continue its excellent work.

MAG FOUNDATION

The MAG Foundation also has continued to expand. Some contributions have been made, and the Woman's Auxiliaries maintain their contributions to the William R. Dancy, M.D., Foundation Fund. The bank balance of the Foundation on December 31, 1969 was \$1,391.97. The balance on December 31, 1970 was \$4,377.54.

The Foundation officers and trustees have held five

meetings during this past year. One of the items recommended by the trustees and forwarded through the MAG Council will give this House of Delegates an opportunity to vote on Bylaws changes allowing county societies to contribute to the Foundation on a *pro rata* basis to underwrite contributions to financially handicapped physicians or their widows.

A new set of officers, and a new trustee have been named for the year 1971. They are as follows:

- John T. Mauldin, M.D., President; term expires December 1973
- J. Frank Walker, M.D., Vice President; term expires December 1974
- J. Rhodes Haverly, M.D., Secretary/Treasurer; term expires December 1972
- Charles R. Andrews, M.D.; term expires December 1971
- Everett Williams; term expires December 1975
- Edwin F. Smith, Ex-officio; term expires December 1976

CHAMPUS PROGRAM

The MAG CHAMPUS Program serves well the patients and physicians of our state. It is still one of the better and larger such programs in the nation, and is one of the few sponsored by and operated by a state medical association. The Department of Defense as well as the participants in the program, both physicians and patients, continue to be pleased with our operation. The following chart is a summary of services for the year 1970.

1970 CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES STATISTICAL REPORT										
	Annual		% Total		Average per month		Average per day		1970 vs. 1969	
	1969	1970	1969	1970	1969	1970	1969	1970	% + or -	
Received—Total	40,183	51,596	100	100	3,348	4,300	157	201	+28.4	
Inpatient ¹		30,965		60		2,580		121		
Outpatient		15,965		31		1,330		62		
Drugs ²		4,722		9		394		18		
Returned	8,358	7,688	21	15	696	641	33	30	-6.0	
Rejected	2,087	3,336	5	6	173	278	8	13	+1.0	
Review Committee	5	24								
Paid—Total	\$27,370	\$41,505	68	80	\$2,281	\$ 3,459	107	162	+51.0	
Regular (inpt. + outpt.) ³	25,379	37,142	63	72	2,115	3,095	99	145		
Handicap		1,001		2		84		4		
Drugs	1,991	3,362	5	6	166	280	8	13		
Total Dollar Amount Paid	\$2,684,855.72	\$4,258,075.06	100	100		\$354,839.59			+58.0	
Regular (inpt. + outpt.)		3,797,488.78		88		316,457.40				
Handicap		349,898.78		9		29,158.23				
Drugs		110,687.50		3		9,223.96				
Average paid per claim										
—Total	\$ 98.10	\$102.60							+4.0	
Regular ³	105.79	102.25								
Handicap		349.54								
Drugs ²	29.04	32.92								

Note:
¹ Includes Handicap Program claims.
² Includes consolidated reimbursements and vendor payments.
³ 1969 included Handicap.



Reference Committee B, diligently considering the items referred for its recommendations.

GENERAL REMARKS

The Headquarter's Office staff has expanded during 1970. The new administrative officer, Mr. Adam Jablonowski, serves as our Health Planner, and two new secretaries now are working in our headquarters office. Mrs. Susan Davis and Mrs. Nancy Dickerson, a former employee, presently are hard at work. Mrs. Sandra Sawyer, wife of our AMA Regional Field Representative, recently delivered a fine baby daughter, and no longer is employed in headquarters office.

The Executive Committee Discretionary Fund has been handled efficiently during 1970. A total of \$620.75 has been allocated during this past fiscal year in three separate allotments. Each of these was considered of sufficient urgency to warrant our not waiting for the next Council meeting to request such disbursement, and in each instance the subsequent Council meeting has approved the Executive Committee's action.

A new Foundation was created in October, 1970. Its official title is the Georgia Medical Care Foundation, Inc., and it has great potential. Dr. F. William Dowda has been elected President, and a Board of Trustees named. I am certain that much discussion will center around this important new effort of the Medical Association of Georgia, and I urge each of you to become familiar with the concepts inherent in it. In the Secretary's Report to the Annual Session in 1969, I gave a quote concerning the duties and responsibilities of a tenured academic professor, drawing a parallel to our own responsibilities as physicians. It was concerned with leading by example and word our junior comrades toward competent, responsible and professional care for our patients, while at the same time having the equal responsibility to police our own ranks of the incompetent and the shabby. This new Foundation has just such possibilities, and at the same time will help us to maintain our own professional integrity as well as our economic well-being.

One personal word that may be of interest to our membership is that your Secretary was named to the Board of Directors and to the Executive Committee of the Association of Schools of Allied Health Professions, a national organization of educators in the Allied Health field. This position is self-satisfying, of course, and flattering, but more than that, allows additional emphasis to Georgia ways of thinking and doing things in this newly emerging and potentially powerful Allied Health group.

From 1900 until 1958, the office of Secretary and Treasurer of the Medical Association of Georgia was a single one. As of June, 1959, the offices were separated for the first time, and Dr. C. J. McLoughlin was elected Secretary, and Dr. C. Raymond Arp was appointed Treasurer. Since that time, these offices have remained separate.

It is appropriate, I think, that an appointed official should not serve as a director along with those individuals who appoint him. It is equally apparent that a fellow physician, appointed to an important office and sitting with his peers, might find it uncomfortable if he does not find it possible to participate fully in policy-making decisions.

Until the early 1960's, the scope of the business of the Association, and the personnel employed by the Association was such that considerable responsibility and work devolved on the Treasurer. Since that time, however, competent and adequate professional workers are employed by the Association to handle financial and bookkeeping matters. The Finance Committee is entrusted with the responsibility for preparing an appropriate budget yearly. The staff of the MAG then carries out the mandates of the budget, under the guidance of the Secretary, the Treasurer, and the Executive Committee, the Council, and the House of Delegates.

Traditionally, the Secretary has been elected by this House, and serves for several years. Traditionally, also he has been a resident of the Atlanta environs, and is able to work closely with the Executive Director and the Headquarters Office staff.

I have felt for some time that change should be made relating to the offices of Secretary and Treasurer. I have not wished to propose such changes while I was still functioning as one of these officers, fearing an implied self-seeking charge. Because Constitutional changes will have to occur, and because any Constitutional changes must sit on the table for one year, I make my suggestions this year, hopefully to be accomplished at the Annual Session of the MAG in May 1972, when I will be retiring from this office. This House of Delegates will have the opportunity to vote, after thorough discussion, on these concepts at this Annual Session meeting, since the Constitution and By-laws Committee will have prepared appropriate language for either alternative.

RECOMMENDATION

I wish to recommend that one of the two following changes be made concerning the office of Secretary and the office of Treasurer of the Medical Association of Georgia.

(1) The Office be recombined into a single, elected office, the term of office to be for the existing period of three years, with the possibility of re-election for one term.

(2) The offices continue to remain separate, but the Treasurer to be elected as are other officers, at the appropriate Annual Session. This term of office should be for three years also, with the possibility of re-election for one term. Incorporated in this choice is that the Treasurer be named simultaneously also the Chairman of the Finance Committee, so that the single office of Treasurer and Chairman of the Finance Committee would exist, and that he would serve on the Executive Committee.

If choice No. 1 were taken, the Chairman of the Finance Committee would continue to be appointed by the Chairman of Council yearly.

I feel that either of these recommendations would remove some obstacles and some problems that exist presently. I urge the House to consider seriously accepting one or the other. As mentioned above, accepting either of these recommendations will demand that Constitutional changes be made, and therefore, the changes will not take place until the Annual Session, 1972.

It has been my privilege and my pleasure to serve as your Secretary during this past year, and I am looking forward with anticipation to the year ahead, as well as with sadness, recognizing that it will be my last year in serving you as your Secretary.

REFERENCE COMMITTEE RECOMMENDATION
—The report of the Secretary of MAG can be divided fairly easily into two distinct reports. The first is a general review of the range of activities of MAG and some of the more relevant activities of the Secretary; and a second report which consists of recommended changes in the Constitution and Bylaws. Permit your Reference Committee to discuss these separately.

With respect to that portion of the report recounting many of the highlights of the Association during the past year your Reference Committee wishes to commend the Secretary for the clarity with which he explains the many and varied activities of the Association in general and the Headquarters Office operation in particular. Your Committee recommends adoption of this portion of the report with the hope that the excellent stewardship given by Dr. Haverty is as obvious to the House of Delegates as it has been to your Reference Committee.

The second part of the Secretary's report addresses itself to amending the MAG Constitution and Bylaws to affect one of two possible changes. These are: (1) Combine the offices of Secretary and Treasurer into the single office of Secretary-Treasurer, elected by the House of Delegates for a three year term, and eligible to succeed himself for one additional term. The alternative, or second recommendation made by the Secretary is that the office of Treasurer remain a separate office, but that it become an elected position of three years duration, eligible to be re-elected to one additional term of office, and that the Treasurer simultaneously serve as Chairman of the Committee on Finance.

Your Reference Committee heard numerous witnesses and devoted considerable time in its consideration of this matter. Based on testimony received the Reference Committee concurs in the numerous expressions, including that of the Secretary, that the recommendation combining the offices of Secretary-Treasurer should not be favorably reported and accordingly your committee dismissed further consideration and addressed itself to the alternative recommendation, i.e., election of the Treasurer by the House of Delegates.

Without exception witnesses endorsed the substance of this recommendation. Controversy arose only as the matter relates to timing. After the most deliberative and exhaustive consideration your Reference Committee wishes to recommend that the office of Treasurer become an elected official, a mem-

ber of Executive Committee of Council and Council with the right to vote. However, it would further recommend that Chairman of the Finance Committee remain an appointed position. An additional recommendation is made that this matter be referred to the Constitution and Bylaws Committee with instructions to research the matter diligently and prepare proper language and that careful study be given to stipulating the length and number of terms of office and the respective duties of the Treasurer and the duties of the Chairman of Finance under such amended Constitution and Bylaws. The Reference Committee is strong in its belief that the right to vote should be accorded the Treasurer but recommends that the House abide by a strict interpretation of the present Constitution and Bylaws and delay until 1972 before receiving the Constitutional amendment to be certain that all possible ramifications of this matter have been worked out by the Constitution and Bylaws Committee.

HOUSE OF DELEGATES ACTION—Delegate Robert Wells, Fulton County Medical Society, moved the following resolution:

"RESOLVED, that the Treasurer of the Association be elected by the House of Delegates for a three-year term and be made a voting member of Council and Executive Committee of Council; that the Chairman of Finance Committee continue to be appointed as presently provided;

"RESOLVED further that this resolution be treated as the first reading of the necessary amendments to the Constitution;

"RESOLVED FURTHER that the matter be referred to the Committee on Constitution and Bylaws for preparation of the exact wording of the amendments to the Constitution and Bylaws and that the amendments to the Constitution be published in the Association's *Journal* during the next year;

"RESOLVED FURTHER that this procedure complies with the provisions of Article XIII of the Constitution so that the matter may be finally voted on at the 1972 Session of the House of Delegates."

This motion was duly seconded. The DeKalb County Delegation moved to amend the resolution to say,

"The Treasurer must be a physician in the active private practice of medicine and be earning the majority of his professional income therefrom."

This proposed amendment failed.

The House then adopted the substitute resolution introduced by Dr. Wells.

Treasurer

JOHN S. ATWATER, M.D., *Atlanta*

Once again, the Treasurer has the privilege of reporting that the Medical Association of Georgia is in good, sound financial condition. Despite rising costs and overhead, there has been an income sufficient to meet the needs of the Association. It is to be pointed out that the funds not immediately necessary for use have been placed where interest rates have been highest and have earned a considerable amount of money for the Association.

I should like to thank most sincerely all those who have had a part in the conduct of this office of Treasurer, especially our most efficient Business Manager, Miss Thelma Franklin.

RECOMMENDATIONS

For some years the Treasurer has felt that the office of Treasurer should be held by an officer elected by the Medical Association of Georgia, therefore, it is recommended that the Reference Committee review this matter and if in agreement, recommend that the House of Delegates instruct the Committee on Constitution and Bylaws to draw up the proper amendment and submit this to the Association for action at the proper time.

REFERENCE COMMITTEE RECOMMENDATION

—Your Reference Committee notes the similarity of the recommendation of the Treasurer and that made by the Secretary, to wit, that the office of Treasurer be an elected office. Your Committee feels that its position on this is adequately expressed in the previous report.

With exception of the recommendation contained in this report, however, your Reference Committee recommends acceptance of the Treasurer's report with the highest commendation and recognition of the splendid job performed by Dr. Atwater over the years.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer as recommended by the Reference Committee.

Constitution and Bylaws Committee

GEORGE H. ALEXANDER, M.D., *Chairman*

Mr. Speaker and members of the House of Delegates: The Committee on Constitution and Bylaws met at the Atlanta Marriott on August 15, 1970, at the time of the Committee Conclave. Another meeting was held in Valdosta, Ga., at the time of Council meeting on December 12, 1970. The Executive Committee of Council at its January meeting referred additional matters to the Committee on Constitution and Bylaws. Again at the February Executive Committee meeting other matters were referred to the Committee for consideration and preparation of the language. The five year review of the Constitution and Bylaws has been done and it resulted in some additional amendments being proposed. The Committee met again on February 19, 1971 and reviewed a preliminary report and three addendum reports. These are all being put together in one document as the Report of the Committee to the House of Delegates. All the foregoing was reviewed and discussed by the Executive Committee of Council and by the Council at the March 6-7 meeting at the Macon Hilton Hotel in Macon.

In the interest of brevity, there will be only minimal quotes from the minutes of the Committee meetings, but the full minutes of the meetings will be available to the Reference Committee or the full House if necessary or desired.

All the items considered will be reported on in the Amendment Resolution. Each item will be followed by the Committee recommendation where one is made. Council action also will be reported. In some instances there may be an explanatory comment.

REFERENCE COMMITTEE RECOMMENDATION

—At the outset your Reference Committee wishes to acknowledge the considerable amount of work done by the Committee on Constitution and Bylaws in

perfecting the numerous amendments—technical and substantive—presented in their report.

Your Committee would first call attention to a technical Constitutional amendment accepted by the House last year, which was properly placed on the table at that time and may now be voted on by the House. The amendment in question resolved that "Article V, Section 1, and Article VI, Section 1 of the Constitution be amended by deleting the words Executive Secretary wherever they appear and substitute the words Executive Director."

Your Reference Committee recommends approval of this amendment.

HOUSE OF DELEGATES ACTION—Approved this portion of the report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

RESOLVED that the Constitution and Bylaws of the Medical Association of Georgia be amended in the following particulars:

ITEM 1: RE: SUCCESSION TO THE PRESIDENCY

Amend Article IX, Section 5, of the Constitution by the addition of a new paragraph at the end of said Section 5 to read as follows:

"In event a catastrophic occurrence should exhaust the aforementioned line of succession to the Presidency, the Speaker of the House of Delegates or the Vice Speaker, if the Speaker is unable to act, shall be authorized to convene an emergency meeting of the House of Delegates for the purpose of naming an Acting President to serve until the next Annual Session. The Acting President, so named, shall have all the powers and duties of the President during the term for which he is elected to serve. Should the Speaker and the Vice Speaker both be unable to act, then five councilors or any 10 delegates shall be authorized to convene the House of Delegates in emergency meeting. Such other acting officers as necessary shall also be named at this time to serve until the next Annual Session."

COMMENT: Realizing that there are occasions when all or virtually all of the officers of the Association are on the same plane and in event of a crash could all be wiped out at one time, thus exhausting the line of succession to the Presidency, the foregoing amendment to the Constitution was proposed by the Committee Chairman, following the five year review. Being a Constitutional amendment, it will have to lie on the table until the 1972 Annual Session and be voted on at that time.

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved 12/13/70.

REFERENCE COMMITTEE RECOMMENDATION

—Item 1: Re: Succession to the Presidency—Article IX, Section 5, provides for the orderly succession to the Presidency in the event of death or inability to serve. It makes no provisions, however, should all those in line to succession be simultaneously incapacitated. This proposed amendment provides the method by which the affairs of MAG would be continued in the face of a catastrophe that eliminated everyone presently in line to succeed to the Presi-

dency. It is a Constitutional amendment, properly drawn and presented and your Reference Committee recommends that it be accepted by the House to lie on the table until 1972 at which time a vote may be taken on its merits.

HOUSE OF DELEGATES ACTION—Accepted the Constitutional amendment to lie on the table until 1972 as recommended by the Reference Committee.

ITEM 2: RE: MEMBERSHIP, HOUSE OF DELEGATES FOR STUDENT AMA CHAPTERS

Amend Chapter III, Section 2, of the Bylaws by adding a new paragraph at the end of said Section 2, such new paragraph to read as follows:

“One representative each from the Emory Medical School and Medical College of Georgia Chapters of the Student American Medical Association shall be ex-officio members of the House of Delegates without the power to make motions or to vote, but with right to be heard at meetings.”

COMMENT: The 1970 House of Delegates approved the representation in the House of Delegates of each of the Student American Medical Association Chapters in Georgia, by each Chapter electing one ex-officio, non-voting, delegate annually. The foregoing amendment has been prepared on direction of the House of Delegates.

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved 3/7/71.

REFERENCE COMMITTEE RECOMMENDATION
—Item 2: Re: Membership, House of Delegates for Student AMA Chapters—The 1970 House of Delegates approved the concept of nonvoting membership in the MAG House of Delegates for one representative each from the SAMA Chapters at the Medical College of Georgia and Emory Medical School.

After due consideration your Reference Committee recommends that this be adopted, but that the words “ex-officio” (by reason of office) appearing on line 9, page 3, be deleted and that an editorial change be made by inserting the word “the” between the words “with and right” appearing on line 11, page 3 of the report.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Constitution and Bylaws with the amendments as recommended by the Reference Committee

ITEM 3: RE: MEMBERSHIP FOR QUALIFIED OSTEOPATHS

Amend the Bylaws by designating the present Section 1 of Chapter I, without change, as Section 1, Paragraph (A). Be it further resolved that a new paragraph be added to be designated as Section 1, Paragraph (B). Said paragraph to read as follows:

“Physicians holding the degree of Doctor of Osteopathy from a College of Osteopathy acceptable to the Council of the Association and licensed for full practice privileges by the Composite Board of Medical Examiners of the State of Georgia and who meet all the qualifications set forth in the immediately preceding paragraph (A) of Section 1, may be

eligible for membership after being certified by the Secretary of a component society and upon paying dues to this Association as hereinafter provided.”

Chapter I, Section 1, as amended, shall then read as follows:

CHAPTER I
Membership

SECTION 1

“(A) A physician holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the state of Georgia, who is a citizen of the United States, and who has not been judged guilty of moral turpitude or other serious crime, may be eligible for membership after being certified by the Secretary of a component society as being a member in good standing of said component county society and upon paying dues to this Association as hereinafter provided.

(B) Physicians holding the degree of Doctor of Osteopathy from a college of Osteopathy acceptable to the Council of the Association and licensed for full practice privileges by the Composite Board of Medical Examiners of the state of Georgia and who meet all the qualifications set forth in the immediately preceding paragraph (A) of Section 1, may be eligible for membership after being certified by the Secretary of a component society as being a member in good standing of said component society and upon paying dues to this Association as hereinafter provided.”

COMMENT: The foregoing language to amend the Bylaws to provide for MAG membership for qualified Osteopaths was prepared at the request of the Executive Committee.

COMMITTEE RECOMMENDATION: Language as prepared approved for introduction for consideration by the House of Delegates, but makes no recommendation for or against passage.

COUNCIL ACTION: Approved 9/19/70.

REFERENCE COMMITTEE RECOMMENDATION
—Item 3: Membership for Qualified Osteopaths—Your Reference Committee recommends that this not be approved at this time.

HOUSE OF DELEGATES ACTION—After considerable discussion of this portion of the Report of the Committee on Constitution and Bylaws, Speaker Ellington put the motion to the House as being on the adoption of the amendment to the Constitution and Bylaws, with the reminder that the Reference Committee recommended that this portion of the Report of the Constitution and Bylaws not be approved. The voice vote was inconclusive and Speaker Ellington called for a standing vote (count: aye 61; no 70). On motion from Dr. F. William Dowda, Fulton County, Speaker Ellington ordered a recount of the standing vote (count: aye 58; no 57). On motion duly made requesting a roll call vote, Speaker Ellington called on Secretary John Rhodes Haverty, M.D., who called the roll of official Delegates. Credentials Committee Chairman W. A. Fuller, M.D., announced the roll call tally as aye 61; no 61. Speaker Ellington declared the vote a tie and ruled that the motion had

failed. Delegate Robert Wells, Fulton County Medical Society, then moved that the following words in lines 20-22 be deleted:

“... who meet all the qualifications set forth in the immediately preceding paragraph (A) of Section 1, ...”

and insert in lieu thereof the words:

“... who is a citizen of the United States, and who has not been judged guilty of moral turpitude or other serious crime, ...”

Delegate Rupert H. Bramblett, Chattahoochee Medical Society, moved to table and the motion was adopted on a voice vote.

On direct question from the floor, Speaker Ellington was asked the effect of the actions taken, and (based on Chapter XIV, AMENDMENTS, which requires a majority vote of the House of Delegates to amend the Bylaws) the Chair announced that the Bylaws amendment had failed.

ITEM: 4 RE: LIFE MEMBERS COUNTED IN DELEGATE APPORTIONMENT

Amend Chapter III, Section 2, of the Bylaws by inserting therein a new sentence at the end of the first sentence thereof. The new sentence to be inserted shall read as follows:

“In arriving at the number of delegates to be apportioned to each component society, life members shall be counted the same as dues paying members and included in the total for purposes of delegate apportionment.”

As amended, Section 2 of Chapter III shall then read as follows:

“Each component county society shall elect one delegate and a corresponding alternate, each of whom has been a member in good standing for the prior three years, for each 25 members, or fraction thereof, whose dues have been paid to the Association by December 31 of the preceding year, provided that each component county society shall be entitled to at least one delegate. In arriving at the number of delegates to be apportioned to each component society, life members shall be counted the same as dues paying members and included in the total for purposes of delegate apportionment. Delegates to the House of Delegates shall serve for a term of three years; one-third of the members of the House of Delegates to be elected annually, provided that component county societies which are entitled to three or more delegates shall elect at their first election one-third of their delegation for a term of one year, one-third of their delegation for a term of two years, one-third of their delegation for a term of three years and thereafter elect such delegates whose terms of office expire therewith. Those component county societies which are entitled to less than three delegates shall elect their delegate or delegates for staggered terms in rotation as may be determined by Council until one-third of the House of Delegates is being elected annually.”

COMMENT: Proposed Item No. 4 was prepared at the request of Executive Committee—its purpose being obvious.

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved 12/13/70.

REFERENCE COMMITTEE RECOMMENDATION
—Item 4: Life Members Counted in Delegate Apportionment—Chapter II, Section 2 of the Bylaws provides for the method by which the number of Delegates to the House of Delegates from each County Medical Society is determined. Specifically, it provides for one Delegate for each 25 members of the Society, or fraction thereof, who have *paid their dues* by December 31 of the preceding year,

The proposed amendment would make possible the inclusion of MAG Life Members, *who do not pay dues*, in the total of each County Society for the purpose of determining the number of Delegates to which each Society is entitled. Your Reference Committee concurs in the equity of this proposal and recommends that it be adopted.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

ITEM 5: RE: ORIGINAL JURISDICTION FOR COMMITTEE ON PROFESSIONAL CONDUCT

Amend Chapter IX, Section 4, Subparagraph (2) of the Bylaws by deleting the semicolon and the word “or” at the end of said subparagraph (2) and then inserting the following:

“, provided the Executive Committee of Council approves acceptance of original jurisdiction of such matter; or”

Subparagraph (2), as amended, then would read:

“(2) On referral from a component county medical society when such society or its Committee on Professional Conduct by whatever name called requests that the Association assume original jurisdiction of the matter in behalf of the county society, provided the Executive Committee of Council approves acceptance of original jurisdiction of such matter: or”

COMMENT: This amendment is being proposed because the Committee on Professional Conduct was concerned over the possibility that large numbers of cases might be referred to them for original jurisdiction. The intent of Subparagraph (2), when originally adopted, was primarily to aid small societies when they might have a problem too close to them to consider objectively. By having Executive Committee acceptance as a screen, it is felt that overloading of the MAG Committee can be avoided.

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved 12/13/70.

REFERENCE COMMITTEE RECOMMENDATION
—Item 5: Original Jurisdiction for Committee on Professional Conduct—Chapter IX, Section 4 of the Bylaws provides that the MAG Committee on Professional Conduct may assume original jurisdiction only when requested to do so by a component county medical society, or when that Society has failed to commence an investigation into a complaint within 90 days after the receipt of a complaint.

The assumption of original jurisdiction by MAG in such matters was intended at its inception to provide a remedy to those component societies that are so small as to make objectivity difficult to achieve.

As stated in the Constitution and Bylaws Committee report the proposed amendment is being offered because the MAG Professional Conduct Committee expressed concern that so many cases may be routinely referred to it as to become an impossible burden to shoulder.

The proposed amendment to Chapter IX, Section 4, therefore, sets the MAG Executive Committee up as a screen by providing that it shall be authorized to accept or reject a request for the assumption of original jurisdiction.

Your Reference Committee recommends approval of this amendment with the observation that should Executive Committee refuse to accept a request from a component county society that such society could appeal its case to Council with a request that Executive Committee be instructed to permit the Professional Conduct Committee to assume jurisdiction. Your Reference Committee is aware of no current Bylaws provision that would prohibit this course of action.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

ITEM 6: RE: MEMBER REINSTATEMENT PROCEDURE

Amend Chapter VIII, Section 3, of the Bylaws by deleting the final paragraph of subsection (2) of said Section 3 and inserting in lieu thereof a new paragraph to read as follows:

“An active member who fails to pay dues or additional dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year’s dues in arrears plus payment of all dues and additional dues in arrears at the time such active member lost membership by delinquency with respect thereto subject to re-application and approval of his county society. Exceptions may be approved by the Council upon recommendation of his local constituent society in cases of financial hardship.”

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved 3/7/71.

REFERENCE COMMITTEE RECOMMENDATION
—Item 6: Member Reinstatement Procedure—Chapter VIII, Section 3 (final paragraph of subsection 2 under Section 3) of the current Bylaws outlines the procedure by which a member may be reinstated to

membership for failure to pay dues for one or more years. Reinstatement under this provision has become routine, but Section 3 fails to provide an equitable method for reinstatement when membership lapsed during a year in which additional dues have been levied.

This House will certainly recall the \$100 additional dues that were levied upon the membership in 1969 by a vote of the House of Delegates. The amendment now being proposed to Chapter VIII, Section 3, would provide that reinstatement be conditioned upon the payment of regular dues for the current year, one year’s dues in arrears, plus payment of all dues and additional dues in arrears at the time when membership was lost.

The purpose of the amendment is to avoid making it financially attractive to drop membership in any year when additional dues may have to be imposed. Your Reference Committee concurs in the soundness of this amendment and recommends its adoption.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

ITEM 7: AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Amend the Bylaws by the addition of the following sentences to Chapter XIV:

“Amendments to these Bylaws or to the Constitution may be proposed by action of the House of Delegates, or by the Council, or the Executive Committee of Council, or by the Committee on Constitution and Bylaws, or by any group of active members numbering five or more. Proposed amendments must be submitted to and received by the Constitution and Bylaws committee not less than (75) seventy-five days prior to the Annual Session, at which they are to be acted upon. In an emergency situation and in the judgment of two-thirds vote of Council, a meeting of the Constitution and Bylaws Committee shall be called to consider additional changes in the Constitution and Bylaws after the (75) seventy-five days prior to the Annual Session.”

Resolved that the Constitution be amended by adding the following sentence to Article XIII:

“Before consideration of any amendment to this Constitution it must go through the Committee on Constitution and Bylaws and the Council as provided in the Bylaws.”

COMMENT: The Amendment involving a change in the Constitution will have to lie on the table for a year or until the Annual Session in 1972, for action by the House of Delegates at that time. It is recommended that the Bylaws change also be held over until 1972 and be acted upon at the same time for obvious reasons.

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved 3/7/71.

REFERENCE COMMITTEE RECOMMENDATION
—Item 7: Amendments to the Constitution and Bylaws—This amendment provides that amendments to

the Constitution or the Bylaws must be received by the Constitution and Bylaws Committee not less than 75 days prior to the Annual Session at which time they are to be acted upon. In addition it enumerates those persons and groups of persons who may propose amendments and further stipulates a method by which emergency situations may be dealt with.

A secondary part of Item 7 provides for a Constitutional amendment that would require all proposed amendments to come to the House of Delegates after consideration by the Constitution and Bylaws Committee and Council.

Your Reference Committee recommends that so much of Item 7 (lines 22-36, page 7 of the report) be adopted, but recommends that the accompanying Constitutional amendment on page 8 be disapproved as these two amendments taken together would hamper the House in its efforts to amend the Constitution and in some cases could result in taking two years to affect a Constitutional change.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

**ITEM 8: RE: CONTRIBUTION OF \$1.00
PER YEAR PER MEMBER FOR
MAG FOUNDATION**

At the request of Executive Committee, the Constitution and Bylaws Committee drew the following language for a contribution of \$1.00 per year per member for the MAG Foundation to be used as restricted funds or indigent members of MAG and their widows:

Amend Chapter VII, Section 6, of the Bylaws by:

(a) Deleting the word "and" immediately preceding the number (5) five.

(b) Change the period at the end of present Section 6 to a semicolon.

(c) Add to the end thereof a new subsection (6) to read as follows:

"... and (6) pay to the Medical Association of Georgia Foundation Inc. the sum of \$1.00 for each active dues paying member of such component county society during each year in which the Council of the Medical Association determines that the payment of such amount is necessary in order to establish a fund for the assistance of indigent members of the Medical Association of Georgia and their widows."

COMMENT: The Committee on Constitution and Bylaws felt that this should be included in the Bylaws, but Dr. Alexander stated that he would offer a minority report to the Committee's report to the House of Delegates against inclusion in the Bylaws as he felt the House of Delegates had the authority to act by resolution to increase dues or request voluntary action by County Medical Societies without a Bylaws change.

COMMITTEE RECOMMENDATION: For passage.

COUNCIL ACTION: Approved submission without recommendation 3/7/71.

**MINORITY REPORT: RE: COLLECTION BY
CONSTITUENT SOCIETIES OF \$1.00 PER
YEAR PER MEMBER FOR THE MAG
FOUNDATION**

The Chairman dissented from the majority report of the Committee and begs leave to state his reasons and conclude with a resolution.

Resolution

WHEREAS, for many years, it has been customary for the Medical Association of Georgia to aid indigent members and their widows up to \$100.00 per month with half of the amount being contributed by the Constituent society and the other half by MAG; and

WHEREAS, it can become burdensome to smaller constituent societies to raise their share month after month; and

WHEREAS, it has been proposed that the constituent society secretaries collect one dollar per year per member to be ear-marked to go to the Foundation or establishing a special fund and that the Foundation in turn assume the responsibility of aiding indigent members or their widows in the amount of \$100 per month; and

WHEREAS, it is felt that an amendment to the Bylaws to require the collection of such funds by the local societies does not belong in the Bylaws; and

WHEREAS, it is felt (although the amount is small) that such an amendment might result in resentment by many members; and

WHEREAS, the House of Delegates has the authority to direct Council to include funds in the Budget to care for this situation; and

WHEREAS, should it be necessary to do so, the House of Delegates has the authority to increase the dues if needed, although this is doubtful.

THEREFORE BE IT RESOLVED, that the House of Delegates instruct the Council to include in its annual budget funds amounting to \$1.00 per member per year to go to the Foundation of the MAG, such funds to be used for the establishment of the MAG Fund for Indigent Members or their Widows.

BE IT FURTHER RESOLVED, that the Finance Committee of Council review the Fund annually and that whenever in their judgment the Fund has reached the point that would justify it, the Finance Committee be authorized to recommend to the Council that appropriation for the Fund be omitted for that particular year.

Your attention is called to the proposed constitutional amendment introduced last May, pertaining to the change in title of Executive Secretary to Executive Director. It is a technical amendment which will come up for a vote at the 1971 meeting. The Constitution and Bylaws Committee recommends its passage.

It is felt, as usual, that Mr. Moffett and Mr. John Moore, our legal counsel, should be commended with appreciation for their valuable assistance to the Committee.

REFERENCE COMMITTEE RECOMMENDATION
—Item 8: Contribution of \$1.00 Per Year Per Member for MAG Foundation—At the request of Executive Committee the Committee on Constitution and Bylaws drafted an amendment to Chapter VII, Section

6 of the Bylaws, the effect of which is to require each component County Medical Society to contribute to the MAG Foundation, Inc. the sum of \$1.00 for each active dues paying member of such Society for each year the Council determines that such monies would be necessary to establish and maintain a restricted fund for the assistance of indigent MAG members and their widows.

The Chairman of the Constitution and Bylaws Committee dissented from the majority and filed a minority report stressing the following points: (1) that an amendment to the Bylaws is not necessary; (2) that some members may resent this action; (3) that the House of Delegates can direct Council to budget for this matter out of general funds; and (4) that the House of Delegates can authorize a dues increase without amending the Bylaws.

Your Reference Committee feels that it is significant that neither the majority or minority reports take exception to the general proposition of creating a fund for indigent members and their widows—they differ only in the method by which such a fund would be created and maintained within the MAG Foundation. The question, therefore, becomes one of method and not of substance.

After considering all aspects your Reference Committee recommends that the majority position be disapproved and that the minority position be adopted. Your Committee can see no wisdom in amending the Bylaws where such is unnecessary.

HOUSE OF DELEGATES ACTION—Adopted this portion of the report of the Committee on Constitution and Bylaws as recommended by the Reference Committee.

Legislation Committee (National)

J. FRANK WALKER, M.D., *Chairman*

Government's growing concern with, and involvement in, the practice of medicine is probably no better illustrated than by the wide range of proposals now pending before the 92nd Congress all under the banner of national health insurance. The various proposals thus far submitted range all the way from the obscure to the prominent; from those which would institutionalize the practice of medicine and eliminate private practice completely, to those so grandiose in concept and so costly in fact as to threaten not only the practice of medicine as it is currently understood, but would threaten the very solvency of the nation in the process.

The 1970 MAG House of Delegates adopted a recommendation of the Committee on National Legislation which in effect was an endorsement of the AMA "medicredit" plan as an acceptable alternative to the various national health insurance schemes then being offered.

Since the "Medicredit" plan was first introduced in 1970 it has undergone extensive revision by the AMA Board of Trustees as the Board has worked steadily on this proposal for the past year.

Because of the many changes that have been made in the AMA proposal since last year and because "Medicredit," or more properly the "Health Care Insurance Act of 1971," represents the medical profession's primary legislative concern in the current Congress, your Committee would like to present an analysis of this proposal for the information, consideration and hopefully the endorsement of the House of Delegates.



John Kirk Train, Jr., M.D., recipient of M.A.G.'s Distinguished Service Award.

In essence the "Medicredit" proposal is a program of federal financing to make available to individuals and families, at all levels of income, protection against the ordinary and catastrophic expenses of illness through a system of voluntary comprehensive health insurance. The program would cover all persons who are under 65 years of age; Medicare would continue for those 65 years old and over.

As of the writing of this report no less than 126 Congressmen have indicated a willingness to co-sponsor the AMA "Medicredit" proposal. It's uncertain at this time just when hearings before the Ways and Means Committee will be undertaken on this bill. The probability of this bill, or of any bill, which embodies any aspect of the national health insurance concept being enacted during the 1971 Session of Congress is remote. There is a much greater probability that it will become a prime political issue in the Presidential campaign and in the Senate and House races in 1972 with the prospect that some form of national health insurance bill be enacted into law in 1973.

The following is an analysis of the AMA's "Medicredit" proposal:

**"HEALTH CARE INSURANCE ACT
OF 1971" (MEDICREDIT)**

**A proposal of Federal Financing of
Voluntary Health Insurance**

FEDERAL CONTRIBUTION

The Government would pay 100 per cent of the premium for basic and catastrophic expense coverage for low-income beneficiaries (an individual and his dependents whose combined income for a taxable year would not give rise to any income tax liability). For others, the Government would provide scaled participation ranging between 99 per cent and 10 per cent, favoring lower-income persons in the payment of premiums for basic coverage, and would pay in full the pre-

mium for catastrophic expense coverage. A table of allowable percentages is included in the bill.

An individual could count as premium paid by him, in computing his credit against tax, 80 per cent of amounts contributed by his employer for his benefit and his family's benefit under an employer's qualified group health care insurance policy or plan.

The extent of government participation would be determined with reference to federal income tax liability of an individual in a particular year (base year). A health care insurance policy, qualified under this program, would run for a 12-month period beginning in the year following (benefit year).

For Example: If in 1970 a family of four had \$6,100 of income, and uses the standard deduction, its tax liability will be \$452. The taxpayer will receive a tax credit of 54 per cent of the basic premium cost, and 100 per cent of the catastrophic expense premium cost, for the purchase of a qualified health care insurance policy or plan.

Assuming a total premium of \$650 (\$600 for the basic coverage and \$50 for the catastrophic expense coverage) his credit will be 54 per cent of \$600, or \$324, plus the full \$50 for the catastrophic expense premium, for a total of \$374. The taxpayer could therefore reduce his income tax liability from \$452 to \$78 (\$452 minus \$374).

For the same family of four, with the same premiums but an income of \$8,000, the credit against tax would be 24 per cent of the \$600 basic coverage premium, or \$144, and an additional \$50 for the catastrophic expense coverage premium, for a total of \$194.

HEALTH INSURANCE CERTIFICATES; INCOME TAX CREDITS

A beneficiary eligible for full payment of premium by the Federal Government would be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Eligible beneficiaries with whom the Government would be sharing the cost of premium could elect between a credit against income tax or a certificate. The carrier, as defined in the bill, would present certificates received in payment of premium to the Federal Government for redemption.

QUALIFICATION OF PARTICIPATING CARRIERS

To participate in the plan, a carrier would have to qualify under state law, offer certain specified coverage, make coverage available without pre-existing health conditions, and guarantee annual renewal. An assigned risk insurance pool among carriers would be utilized as appropriate.

HEALTH INSURANCE COVERAGE

A qualified policy would offer comprehensive insurance against the ordinary and catastrophic expenses of illness. Basic benefits in a 12-month period would include 60 days of inpatient care in a hospital or extended care facility (but any two days in an extended care facility would count as one of the 60 days). Other basic benefits would provide emergency and outpatient services and all medical services provided by doctors of medicine or osteopathy. The catastrophic expense protection would pay incurred expenses for benefits in ex-

cess of the basic coverage, such as additional days in a hospital or extended care facility, blood (after three pints), and prosthetic appliances.

DEDUCTIBLES

A policy purchased under this program will contain:

(a) Under the basic coverage—a deductible of \$50 per hospital stay, and 20 per cent coinsurance on the first \$500 of medical expense and on the first \$500 of emergency or outpatient expenses incurred by the family during the 12-month policy period; and

(b) Under the catastrophic illness provisions—a corridor, between the basic coverage and the catastrophic illness coverage, of expenses to be incurred by the beneficiaries before payments under the catastrophic illness provisions would begin. The amount of the corridor would be based on taxable income (that is, net income after all tax deductions and personal exemptions): 10 per cent on the first \$4,000, 15 per cent on the next \$3,000, and 20 per cent thereafter.

The family of four, having an adjusted gross income of \$6,100, would have a taxable income (after all tax deductions) of \$2,900.

Deductibles and coinsurance incurred by the family would be applied as credits toward satisfaction of the corridor.

HEALTH INSURANCE ADVISORY BOARD

A health insurance advisory board of 11 members, a majority of whom shall be practicing physicians, and including the Secretary of HEW and the Commissioner of Internal Revenue and other persons qualified by virtue of education, training or experience, would be appointed by the President with Senate consent. The Board would establish minimum qualifications for carriers, and in consultation with carriers, providers and consumers would develop programs designed to maintain the quality of health care and the effective utilization of available financial resources, health manpower and facilities. It would report annually to the President and Congress.

CONGRESSIONAL LUNCHEON TRIP

Your Committee once again held its annual Congressional Luncheon in Washington in April, 1970 (as of the writing of this report its 1971 Luncheon is also scheduled for April), and the turnout, as in years past, was good. All members of the Georgia Delegation in the House and Senate are invited to these luncheon meetings and each Representative and Senator is hosted by a physician constituent. During the morning hours preceding the luncheon our doctors visit with their Congressmen for a frank, free-wheeling discussion of medical legislation pending or apt to be introduced. These meetings have served the profession well in Georgia by constantly improving the rapport between elected officials and practicing physicians.

RECOMMENDATIONS

Your Committee recommends that the House of Delegates reaffirm its endorsement of the "Medicredit" plan with the observation that there will apparently be some form of national health insurance enacted by the Congress and that the AMA's "Health Care Insurance Act" appears to be the most workable and acceptable

under the circumstances of all the various proposals now pending.

REFERENCE COMMITTEE RECOMMENDATION
—The Committee for National Legislation has asked this House to reaffirm its previous (1970) endorsement of the AMA “Medicredit” proposal now pending before the Congress. Acknowledging the fact that the AMA Board of Trustees has been working on and making changes in this proposal steadily since last year, your Reference Committee recommends that the House do, in fact, reaffirm its endorsement of this proposal. It further recommends that the recommendation portion of the National Legislative Report be amended by placing a period after the word “plan” on line 25, page 5 of the report and deleting all that follows.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Legislation (National) with amendments recommended by the Reference Committee.

Legislation Committee (State)

HARRISON L. ROGERS, JR., M.D., *Chairman*

Preoccupation with taxes and appropriation of funds is a short but wholly accurate description of the 1971 Georgia General Assembly. Increasingly concerned with its ability to finance State services, the General Assembly focused its attention on money matters and all other matters were considered secondary to this vital aspect of the legislative process. The Department of Health in particular and the medical profession in general suffered a tremendous public relations loss in the wake of gross misunderstanding of the operation of the Medicaid program. Computer print-outs of physicians who had earned more than \$25,000 under the Medicaid program were distributed by the Health Department under request of the Budget Officer for the General Assembly. Without seeking an explanation of this data the Appropriations Committees of the House and Senate reacted emotionally in a way that reflected adversely on the entire profession.

Allocation of funds for the Medicaid program were cut from six million (State matching funds) to three million (State matching funds) and it was only after considerable work by many people interested in the program that the three million appropriation was sustained.

The above is but one example of the fact that the medical profession must, in the name of survival, expand upon its legislative commitment, improve its technique, and above all, increase the number of its practitioners who will assume a vital and effective role in the field of legislation.

Notwithstanding its preoccupation with taxes and spending the General Assembly still found time to act upon many matters of importance to the medical profession. The following is an account of some of the bills of general importance and interest to the profession that were considered by the 1971 Georgia General Assembly: (As of the writing of this report none of the bills discussed below have been signed or vetoed by the Governor).

(1) **BLOOD WARRANTY (H.B. 582)**—This bill declares that the collection, distribution or transfusion of blood or human organs shall be considered a medical service and not the sale of a product subject to implied

warranties under the Uniform Commercial Code. MAG supported this bill which passed both House and Senate.

(2) **BLOOD AND TISSUE BANKS (H.B. 372)**—This bill brings blood banks and tissue banks under the licensure and regulatory provisions of the Clinical Laboratory Act passed in 1970. MAG supported this bill which passed House and Senate.

(3) **VENEREAL DISEASE AND DRUG ABUSE (S.B. 42)**—Pursuant to this bill physicians are now authorized to treat minors for venereal disease or drug abuse (or suspected VD or drug abuse) without being required to have prior parental consent. The physician may elect to advise the parents of the treatment given, but is not required to do so. MAG supported this bill which passed House and Senate.

(4) **BOARD OF MEDICAL EXAMINERS (S.B. 95)**—This bill authorizes MAG to nominate to the Governor for appointment to the Board of Medical Examiners three physicians for each M.D. vacancy on the Board. The Governor may ask for two additional nominees for a total of five from which he must make the appointments. This bill becomes effective January 1, 1975.

(5) **ALIEN PHYSICIAN LICENSURE (H.B. 60)**—This bill provides that an alien physician who meets all of the requirements of the Medical Practice Act (except citizenship) may be issued a license to practice medicine in Georgia. In addition to the present requirements of the Medical Practice Act noncitizen physicians must have been residents of the United States for one year, file a declaration of intent to become a citizen and exercise his right of citizenship within seven years. MAG supported H.B. 60 on the basis of Executive Committee approval. The bill cleared both the House and Senate on March 5. Two days later the MAG Council reversed the position of Executive Committee to put MAG on record in opposition to H.B. 60. Efforts to obtain the Governor’s veto were not successful.

(6) **CLINICAL LABORATORY-SCHOOLS (S.B. 280)**—This bill provides that schools training personnel for work in clinical laboratories must be licensed by



Roger O. Egeberg, M.D., Assistant Secretary for Health and Scientific Affairs, H.E.W., panel discussion participant.

the Health Department; it provides further for inspections and evaluations of the schools by the Health Department, and for the appointment (by the Board of Health) of an Advisory Committee to work with the Board and the Department in the implementation of this Act. MAG supported this bill which passed both the House and Senate.

(7) **WORKMEN'S COMPENSATION (H.B. 989)**—This bill makes two provisions of particular interest to physicians. They are: (1) Unlimited medical coverage subject to the judgment of the Board of Workmen's Compensation for any amount in excess of \$5,000; and (2) Expansion of the compensable diseases covered by the Act through a "catch all" phrase. Burden of proof that the disease is work related is upon the employee. MAG supported this bill and it was passed by both House and Senate.

(8) **MEDICAID STUDY COMMITTEE (S.R. 151)**—Senate Resolution 151, adopted on the last day of the session, creates a Senate level Medicaid Study Committee to function during the interim. This is an outgrowth of the concern expressed by the General Assembly over the increasing cost of the Medicaid program in Georgia.

(9) **MEDICAL CONSENT (H.B. 321)**—This bill specifically enumerates those persons who may give consent for medical or surgical treatment in Georgia. Two specific categories of interest to the Medical Profession are: (1) Any minor 18 years of age or over for themselves; and (2) any female regardless of age or marital status when given in connection with pregnancy or childbirth. This bill does not relate to abortion, sterilization or mental illness. MAG supported this bill which passed both House and Senate.

(10) **FLUORIDATION (H.B. 213)**—This bill would have authorized the Board of Health to require fluoridation (one part fluoride to one million parts of water) in potable water supplies of incorporated areas of 5,000 or more population. This bill passed the House, was reported favorably from Senate Committee but tabled on the Senate floor. It remains a live bill and could be taken from the table next year. MAG supported this bill.

(11) **AMBULANCE SERVICE (H.B. 370)**—Pursuant to this bill operators of ambulance services would be required to assign drivers who had been given certain basic instruction in first aid. It would also require that the ambulance be equipped with certain standardized equipment. The bill was tabled in the House and later recommitted to the Committee on Health and Ecology. It remains a live bill for consideration next year. MAG supported this bill.

(12) **ABORTION (H.B. 647)**—This bill would have amended Georgia statutes on abortion with five basic provisions: (1) Elimination of the Hospital Abortion Committee; (2) Permits an abortion to be performed in any state-licensed hospital (not JCAH only); (3) Gives physicians the right to elect *not* to participate in an abortion for *any* reason; (4) Provides for a 10-day Georgia residency period; and (5) Exempts from the definition of Criminal Abortion an abortion performed prior to the completion of the 16th week of gestation. This bill was favorably reported from the House Health and Ecology Committee and scheduled to be called up for a vote on the last day that the House leadership had agreed it would consider House

Bills (it traditionally takes up only Senate Bills the last week of the session). For a variety of reasons the bill was not called for a vote and the authors requested it be taken off the Rules Calendar and returned to the General Calendar. The net effect is that it remains a live bill and will be recommitted to Committee next year. MAG supported this bill.

(13) **PSYCHOLOGY-INSURANCE (H.B. 431)**—This bill provided that any health insurance policy that covered mental illness must reimburse clinical psychologists for health care rendered. Bill stymied in Committee with a "Do Not Pass" label. MAG opposed this bill on grounds that it violated the right of contract and that non-medical health practitioners should provide their service in meaningful collaboration with physicians and not independently.

(14) **OPTOMETRY (S.B. 103)**—The optometrist's so-called "freedom of choice" bill would have prohibited agencies of State Government who have assumed responsibility for the health care of any of our citizens from referring patients to family physicians or other medical practitioners for diagnosis and treatment. Under the terms of this bill such a referral would have constituted a violation of the patient's right to choose a practitioner of his own selection. MAG opposed this bill and it was given a "Do Not Pass" label in the Senate Health and Welfare Committee.

(15) **MARRIAGE LICENSES (S.B. 339)**—This bill eliminates the exceptions in the existing law from a required three-day waiting period between the time of application for a marriage license and the granting of the license. MAG supported this bill. No action was taken on it during this session, but it remains a live bill for consideration at the '72 session.

(16) **COUNCIL ON MATERNAL HEALTH (H.B. 1044)**—This bill was introduced late in the session and no MAG position was ever developed. It provides for the appointment of a 10-man Council on Maternal Health by the Governor. MAG would furnish the Governor a list of the persons to be named to this Council.

(17) **CERTIFICATE OF NEED (S.B. 341 and H.B. 1102)**—Both of these bills were introduced two or three days prior to adjournment and as a consequence neither made any progress through the legislative mill beyond receiving a first reading. They remain as live bills and can be considered next year. The bill provides that no hospital or related institution may be constructed or expanded until a "certificate of need" has been issued by the Department of Health. MAG will oppose these bills at the 1972 session of the General Assembly.

(18) **CHIROPRACTIC**—The chiropractors sponsored two "housekeeping" bills of no particular concern. Both related to the operation of their Board of Examiners, i.e., licensure renewal fees and subject matter for testing purposes.

After a careful evaluation of the legislative climate during the 1971 session, it was decided that '71 was not the right time to introduce any of the package of bills being considered by MAG to restrict the growing practice of chiropractic. Your Legislative Committee will continue to function in conjunction with the Quackery Committee with a view toward introducing legislation on the subject of chiropractic at the appropriate time.

(19) **DOCTOR-OF-DAY**—The Doctor-of-the-Day program continues to be MAG's most successful pub-

lic relations project. The project, under the guidance of Drs. Charles B. Watkins, Chamblee, and James A. Kaufmann, Atlanta, has attracted considerable attention over its three years of operation. Your Committee wishes to express its gratitude to those physicians who gave a day's volunteer service to be the Doctor-of-the-Day. Your Committee would also extend its sincere thanks to Mr. Hewlett Sumlin, Administrator of Piedmont Hospital, for scheduling the services of nurses (one week each), to the nurses who helped tremendously in this project, and to the Atlanta area hospitals who furnish the nurses.

COMMENDATIONS—The increasing involvement of government at all levels in the practice of medicine and the attendant view that problems have a legislative remedy serves to make more imperative a corresponding increase in the involvement of "hometown" physicians in the legislative affairs of MAG. Your Committee is appreciative of the help and assistance given by many physicians during the 1971 session and wishes to express its gratitude for their splendid cooperation.

RECOMMENDATIONS

(1) Last year your Committee recommended to the House of Delegates that the House should urge all County Medical Societies to meet with their representatives to discuss chiropractic and other legislative matters. What was merely a good idea last year has now become absolutely essential for the 1972 session. Your Committee urges that such a project not be given a low priority by local Medical Societies to be handled by one physician at the last minute on a makeshift basis, but rather that it be a well planned and sophisticatedly executed project of the whole Society well in advance of the 1972 session of the General Assembly.

(2) Your Committee recommends that the House of Delegates develop a broad policy position on the question of abortion as the best means to refute allegations by legislators, physicians, the church, and members of the general public that the position articulated by the Legislative Committee (on approval of Executive Committee) does not, in fact, represent the view of the medical profession on this sensitive subject. We, therefore, recommend approval of the five specific points enumerated in the previous section on abortion legislation.

Once again your Committee would like to point out the exceedingly valuable service rendered to the Association by Mr. Jim Moffett, our Associate Director, who is in charge of legislative affairs. His unique capabilities and tireless efforts in our behalf have largely been responsible for our success during this legislative year and those of the recent past. Recognition of his worth should certainly be conveyed to the Executive Committee of MAG.

Legislation Committee (State)

HARRISON L. ROGERS, M.D., *Chairman*

As of the date on which the Report of the Committee on Legislation (State) was filed with the House of Delegates the ultimate status of certain bills that had been passed by the General Assembly was unknown.

Under Georgia law the Governor has 35 days following adjournment during which he must either sign the bill into law, veto it, or permit it to become law with-

out his signature. For the 1971 Session of the General Assembly the Governor had until April 16, in which to exercise one of the above mentioned prerogatives.

Listed below are the bills of interest to MAG that were passed by both House and Senate, together with the final status of each noted. This Supplemental Report should be read in conjunction with the original report filed by the Committee on Legislation (State).

The following were SIGNED INTO LAW by the Governor:

H.B. 582 (Act No. 442)—Blood exempt from implied warranties.

H.B. 372 (Act No. 120)—License and regulate blood and tissue banks.

H.B. 60 (Act No. 87)—Alien physician licensure.

H.B. 989 (Act No. 798)—Workmen's Compensation (unlimited medical coverage, but Board must approve all in excess of \$5,000).

H.B. 321 (Act No. 403)—General medical-surgical consent bill (enumerates those authorized to give consent for themselves and for others).

S.B. 42 (Act No. 298)—VD and drug abuse treatment for minors without parental consent.

S.B. 95 (Act No. 694)—Appointment of Board of Medical Examiners by Governor on recommendation from MAG. Effective January 1, 1975.

The following was VETOED by the Governor:

S.B. 280 (Veto No. 15)—License and regulate schools that train personnel for work in clinical laboratories.

Resolution 71-2

County Society Members/Legislators Meeting

RICHMOND COUNTY MEDICAL SOCIETY

WHEREAS, close communication between physicians and members of the State Legislature is necessary in order for physicians to have knowledge of the many legislative bills pertaining to health care in Georgia and for legislators to be aware of the opinions and pertinent facts which can be furnished by physicians; and,

WHEREAS, such communication can best be established by direct personal conversation between physicians and legislators; therefore be it

RESOLVED, that the Medical Association of Georgia strongly urge all of its component medical societies to hold meetings at least once annually between representatives of the component societies and their local members of the Georgia State Legislature.

REFERENCE COMMITTEE RECOMMENDATION

—Because of the similarity of the contents of the reports of the State Legislative Committee, Supplemental Report 71-1 and Resolution 71-2, these were considered together.

Recommendation 1 of the State Legislative Committee calls for an urging that all County Medical Societies hold meetings with their State Senators and Representatives to discuss chiropractic and other legislative matters. Resolution 71-2 makes substantially the same recommendation. Supplemental Report 71-1 merely records those bills of interest that were passed by the General Assembly that were signed or vetoed by Governor Carter.

Your Reference Committee recommends that Recommendation 1 of the State Legislative Committee

and Resolution 71-2 be approved with the additional recommendation that whenever possible that MAG give support to such county society meetings as may make such meetings more meaningful.

HOUSE OF DELEGATES ACTION—Adopted Recommendation (1) of the report of the Committee on Legislation (State) and Resolution 71-2 as recommended by the Reference Committee.

REFERENCE COMMITTEE RECOMMENDATION—Recommendation 2 of the State Legislative Committee Report asks for the development by this House of a broad policy position on the matter of abortion legislation.

Your Reference Committee was presented with a statement of conclusions that could be drawn from the results of the MAG survey on abortion taken last summer and fall. The following is a copy of that statement which upon examination and consideration, your Reference Committee feels is an accurate statement of fact: The Statement reads:

SURVEY OF PHYSICIANS' ATTITUDES

(1) The overwhelming majority of Georgia physicians would approve of abortion for valid medical reasons as outlined in the 1968 Georgia Abortion Law, and for incest, which is not specifically mentioned in this law.

(2) A large majority of Georgia physicians feel that the consent of the husband should be obtained prior to the performance of any abortion.

(3) The majority of Georgia physicians feel that abortions should be performed in hospitals accredited by the Joint Commission on Accreditation of Hospitals.

(4) Abortion for various personal, social and financial (non-medical) reasons are favored by anywhere from a substantial minority to a small majority of Georgia physicians, but abortion on request is not approved by the majority.

(5) The most conservative attitudes concerning indications for abortion are expressed by those Georgia physicians who would be asked to perform them. Obstetricians, Gynecologists and General Practitioners. These groups consistently failed to approve of abortion on request, and for most social and economic indications.

(6) Conscience Clause—Physicians should be protected from liability for declining to perform abortions for any reason.

Based on the above statement your Reference Committee recommends that MAG take no position on House Bill 647 (abortion legislation) now pending in the Georgia House of Representatives, pending the outcome of the decision of the U.S. Supreme Court in a case testing the constitutionality of the 1968 Georgia statute on abortion.

HOUSE OF DELEGATES ACTION—Delegate Robert Wells, Fulton County Medical Society, moved that the House not accept the Reference Committee recommendation and moved that the House approve the elimination of the hospital abortion committees. Delegate Jack Raines, Muscogee County Medical Society, requested a division of the question. On the rejection of the Reference Committee's report, the Speaker, Dr. Ellington, announced the results of a standing vote as in favor of rejection: 67; opposed to rejection: 35.

Delegate Robert Wells then moved that the MAG adopt a position favoring the elimination of hospital abortion committees. This motion was duly seconded and adopted.

Delegate Robert Wells then moved that the position of MAG on abortions being performed in any state licensed hospital be rejected and that MAG's position favor abortions being performed only in hospitals approved by the JCAH. This motion was duly seconded and adopted.

Delegate Robert Wells moved that MAG approve giving physicians the right to select not to participate in an abortion for any reason. This motion was duly seconded and adopted.

Delegate Robert Wells moved that MAG adopt no position on the provision for a 10-day Georgia residency period for patients seeking abortion. This motion was duly seconded and adopted.

Delegate Robert Wells moved that MAG adopt a position that would exempt from the definition of criminal abortion an abortion performed prior to the completion of the twentieth week of gestation. Delegate Rufus Bramblett presented a substitute motion that MAG not adopt a position on the length of gestation, which failed on a voice vote.

Delegate James Kaufman then moved the following substitute resolution:

"RESOLVED, that the Medical Association of Georgia opposes any statutory provision limiting abortions by reference to length of gestation, believing this matter should be left to the judgment of the attending and consulting physicians;

RESOLVED FURTHER, that if the General Assembly insists on a statutory limitation of length of gestation, that the period specified be not less than 20 weeks;

RESOLVED FURTHER, that this action is not to be construed as supporting allowance of abortion on request or on demand."

This resolution was seconded by Delegate F. William Dowda and adopted.

Ad Hoc Committee on Quackery

JAMES A. KAUFMANN, M.D., *Chairman*

The MAG Ad Hoc Committee on Quackery, appointed by the Council during the early summer of 1970, held its organizational meeting in June of 1970, to discuss the overall problem of quackery and to make initial decisions as to the type program the Committee would conduct.

At its organizational meeting the Committee concluded that the overriding quackery problem in Georgia was the growing menace of chiropractic and accordingly decided that its activities would be centered on ways and means to expose this problem to the public. The Committee also concluded that a legislative remedy was the ultimate solution to the problem in Georgia. Activities along these lines were begun.

A number of meetings with various groups in the state were held, including those with representatives of labor and other groups interested in the public health. Discussions were held with professional public relations firms to explore the problems of chiropractic and ascertain how a foundation could be built on which to exert a concerted effort to "unmask" chiropractic.

A very well written and authentic book published by America's largest publisher, "At Your Own Risk," which

is a devastating indictment and exposé of chiropractic, was mailed to all members of the General Assembly as well as to key physicians and other public spirited citizens.

A number of meetings were held with local medical societies to discuss this problem. Local societies were asked to appoint committees, and it was somewhat of a disappointment that only 13 county societies actually appointed such committees and advised the Headquarters office of their appointments.

It was decided that never again should medicine fight a defensive battle against the onslaught of chiropractic in the State of Georgia. Over the years we have been harassed by attempts of chiropractors to obtain laws to require compulsory insurance coverage, when, in fact, the history of such insurance coverage has been one of total disaster. They have also in the past attempted to obtain laws allowing them to spread their menace at public expense by compulsory coverage of their cult in Medicaid.

It is our plan to introduce positive legislation at the appropriate time to rid this state of the menace of chiropractic. Such legislation has been prepared by our legal counsel in the form of four bills which will be introduced at the appropriate time.

Early developments in the legislature, in the absence of chiropractic introduced legislation, clearly pointed to the fact that the 1971 General Assembly would be preoccupied with a new Governor, the new Governor's program, taxes and appropriations. Because of this fact it was decided that 1971 was not the year for a campaign of the scope and intensity that would be required to pass the appropriate legislation.

No attempt was made by the chiropractors this year to introduce significant legislation, and we feel that this was due in part to the activities of this Committee and the fact that the chiropractors had obtained knowledge of the legislation contemplated for introduction by the Committee. However, if legislation is introduced by the chiropractors to further their tentacles on the people of Georgia it is our intention to immediately proceed with our recommended legislative proposals.

In addition to the chiropractic problem, the Committee also gave consideration to the growing menace of hypnosis by unqualified persons and made several investigations. Your Chairman participated in one television program in exposing this growing menace. This is a program which will be further presented to this Committee in the coming year.

We feel pleased with the results obtained to date both in the Legislature and in the field of public information. We feel that this is only a beginning, however, and that greater participation is indicated in the future because the quacks are becoming better financed, better organized and more sophisticated year by year. The fact that the quacks' legislative program was abated this year is a significant accomplishment. We feel that the next session of the General Assembly will be even more significant.

RECOMMENDATIONS

(1) Your Committee recommends a continuation of the Committee on Quackery with a budget of sufficient size to permit it to do the job it was created to do. We feel that the challenge will be even greater in the future than it has been in the past, and that against forces of evil that are well financed the dangers to the

public health will be significant and will extend beyond the field of the endeavors of the quacks.

(2) Your Committee recommends that the House of Delegates urge all county societies to appoint local quackery committees composed of those physicians who have a genuine interest in the problem; that county societies be requested to meet with their representatives and senators in cooperation with the members of the Quackery Committee to discuss the growing problem of chiropractic and quackery.

REFERENCE COMMITTEE RECOMMENDATION

—The Committee on Quackery asked that it be continued and given a budget of sufficient size to permit it to do the job prescribed for it by the Council last year. Your Reference Committee gave considerable attention to this report as a reflection of its awareness of the importance of the problem. Accordingly, your Committee recommends approval of this report with an amendment on the last line (line 22, page 3) that would add the word "other" immediately before the word quackery.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Quackery as amended by the Reference Committee.

Resolution 71-5

Chiropractic Legislation

HALL COUNTY MEDICAL SOCIETY

WHEREAS, the Hall County Medical Society recommends to the Medical Association of Georgia through the Ninth District Medical Society that the Medical Association of Georgia promote legislation which would require chiropractors to take and pass the same examination given physicians before they are licensed to practice in Georgia.

REFERENCE COMMITTEE RECOMMENDATION

—The Hall County Medical Society resolution calls for legislation that would require chiropractors to pass the same examination given to physicians before granting them a license. Again, your Reference Committee recognizes the full magnitude of the problem and recommends that this resolution be referred to the Committee on Quackery to be considered along with the numerous proposals now under active consideration by this Committee.

HOUSE OF DELEGATES ACTION—Adopted Resolution 71-5 and referred it to the Committee on Quackery as recommended by the Reference Committee.

Chairman McGahee then stated that he wished to thank all the members of the Reference Committee for the long and diligent attention given to all the matters referred to this Committee, and moved that the Committee report be adopted as a whole. This motion was duly seconded and approved.

Report of Reference Committee C

Joe C. Stubbs, M.D., Chairman

Chairman Stubbs reported to the House that the reports and resolutions referred to Reference Committee C had been considered by the Committee which



Stuart H. Prather, Jr., M.D., Mrs. Luther Vinton, Dr. Vinten and Mrs. Prather (l. to r.), enjoying the GaMPAC exhibit.

met at 9:00 a.m., in the Thornwood Suite, Marriott Motor Hotel, Atlanta, on May 15, 1971. Members of the Committee present included: Joe C. Stubbs, M.D., Valdosta, Chairman; Philip M. Jardina, M.D., Decatur, Vice Chairman; Donald R. Rooney, M.D., Marietta; Hugh S. Thompson, M.D., East Point; and J. L. Boss, M.D., Villa Rica.

Allied Health Careers Committee

JOHN T. GODWIN, M.D., *Chairman*

The committee has continued to function throughout the year with attendance at various committee meetings related to Allied Health Careers.

The problem of recruiting of health careers' personnel continues to be a major unsolved one. The Chairman has been involved with Health Careers Council of Georgia, Inc. which has also been attempting to solve the problem of recruitment.

At the present time the financial support of the Health Careers Council has been inadequate to support a sufficient number of personnel to adequately function in solving the major problem of recruitment.

It is hoped that the Health Careers Council may continue and will in time grow with additional financial support.

RECOMMENDATIONS

(1) It is recommended that the Medical Association of Georgia, the Georgia Hospital Association and the Regional Medical Program along with other organizations support the Allied Health Careers Council to the extent that a full-time secretary may be employed.

As promoted many years ago, it is believed that the Medical Association of Georgia could contribute greatly toward a solution of Health Careers recruitment by employing a sufficient number of people to promote a program over the State. It is believed that three people in the MAG office could effectively work toward a solution of this problem throughout the State.

(2) It is recommended that in addition to Mr. Jablonski and Mr. Bailey an additional field person of

equal caliber be obtained in order to promote Health Careers recruitment, placement, continuing education and community counseling throughout the State.

It is my belief that in view of the many divergent organizations with their varied interests, an effective solution to the problem will be difficult to accomplish. It is believed that recruitment and placement is one of the most serious problems facing the medical profession in view of the increasing needs of personnel, and the fact that we cannot function effectively without adequate Allied Health Professions. It should behoove us to move rapidly toward solving this problem.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee recommends approval of Recommendation (1) with the deletion of the words "Georgia Hospital Association and the Regional Medical Program" in lines 15 and 16 of Page 1 and the deletion of the words "to the extent that a full-time secretary may be employed" in lines 17 and 18, of Page 1, inserting after the word "Council" the words "within each organization's budgeted limits," and deleting all of lines 19 through 25 so that Recommendation (1) would read as follows:

"It is recommended that the Medical Association of Georgia, along with other organizations, support the Allied Health Careers Council within each organization's budgeted limits."

Your reference committee recommends adoption of the intent of Recommendation (2) by substituting the following language in place of lines 26 through 30 on Page 1:

"It is further recommended that an additional field person be employed whose duties shall include the promotion of Health Careers within the limits budgeted by the Medical Association of Georgia."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Allied Health Careers with the amendments recommended by the Reference Committee.

Georgia Medical Care Foundation

F. W. DOWDA, M.D., *Atlanta*

As all of our members know, our Medical Care Foundation is patterned after those which have previously functioned well in California, particularly the San Joaquin Medical Care Foundation in Stockton, Calif. under the direction of Dr. Donald Harrington. Dr. Harrington will be here to discuss Foundations again at our Annual Session.

RECOMMENDATIONS

I recommend the Medical Association of Georgia establish as an operating policy that those who participate under the Medical Care Foundation concept in the field of Peer Review and also in the field of decision making on the Board of Directors must be practicing physicians. Consultation can be obtained from other non-practicing parties as is deemed necessary by our Utilization and Peer Review Consultants and by the Board. The final decision making must rest in the hands of those who are actively practicing or we have indeed destroyed a basic concept of Peer Review and I would recommend that this be established as an operating policy of the Medical Association of Georgia.

Supplemental Report 71-5

Medicaid Contract with Georgia Medical Care Foundation

MAG COUNCIL

The Medical Care Administrative Committee of the Georgia State Board of Health will recommend to the Board of Health that a contract be negotiated with the Georgia Medical Care Foundation to set up parameters and to review claims of physicians, hospitals, and nursing homes under Medicaid for a period of six months.

The Committee suggests to the House of Delegates of the Medical Association of Georgia the following:

1. That the House assure the Board of Health of their total endorsement of this Foundation program, and assure the Board of adequate review mechanism for Medicaid claims.

2. That membership of the Board of Directors of the Georgia Medical Care Foundation shall be comprised of physicians in full-time private practice of medicine chosen on a statewide basis.

3. That final authority in all claims reviewed reside by law in the Georgia State Board of Health.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee has been exposed to the concept of the Medical Care Foundation for a relatively short time. Certain questions about the Foundation were raised before your reference committee.

1. Can the Foundation administratively and mechanically handle the large volume of claims which will result from the Medicaid Program?

2. What is the mechanism of peer and utilization review available to the Foundation?

3. Is there adequate geographical representation of physicians on the Foundation Board of Directors?

4. What is the reason for the urgency of entering into this Medicaid contract?

These questions were answered to the satisfaction of your reference committee. Therefore, based on the information obtained through lengthy testimony, discussion and deliberation, your reference committee recommends adoption of the Report of the Georgia Medical Care Foundation, 71-5, with the deletion of the words "practicing physicians" in line 12 and in their place the insertion of the words "physicians in the active private practice of medicine and be earning the majority of their income therefrom," so that the sentence reads:

"I recommend the Medical Association of Georgia establish as an operating policy that those who participate under the Medical Care Foundation concept in the field of Peer Review and also in the field of decision-making on the Board of Directors must be physicians in the active private practice of medicine and be earning the majority of their income therefrom."

Your reference committee further recommends the endorsement of Supplemental Report 71-5—Medicaid Contract with Georgia Medical Care Foundation.

HOUSE OF DELEGATES ACTION—A motion by Delegate Newton Turk, Fulton County Medical Society, seconded by F. William Dowda, Fulton County Medical Society, which would have added the word "professional" before the word "income" so

that the last sentence of the Reference Committee's amendment would read:

"... and be earning the majority of their professional income therefrom." failed.

The House of Delegates then adopted the report of the Georgia Medical Care Foundation as amended by the Reference Committee.

The House of Delegates adopted Supplemental Report 71-5 as recommended by the Reference Committee.

Physician-Lawyer Liaison Committee

J. FRANK WALKER, M.D., *Chairman*

The Joint Medico-Legal Committee has been reasonably busy this past year in its attempts to mediate and/or arbitrate disputes arising between individual physicians and attorneys. When applicable, the MAG committee has referred disputes to local county jurisdictions, such as those referred to the Joint Medico-Legal Committee of the Fulton County Medical Society.

We continue to utilize the "Principles Governing Physician-Attorney Relationships" as approved and adopted by the Medical Association of Georgia and the State Bar of Georgia in 1969.

Your co-chairman, Ogden Doremus of Savannah and I, addressed the Gainesville Northeast Bar Association in November, 1970, with an explanation and discussion of "Principles Governing Physician-Attorney Relationship." We are informed that this presentation was extremely valuable, not only for the lawyers in attendance, but also for the many physicians of Gainesville who attended.

Following a meeting of the Joint Medico-Legal Committee January 14, 1971 at the MAG headquarters, both physicians and lawyers of the Joint Committee met with the Committee on Insurance and Economics of the Medical Association of Georgia for the purpose of discussing problems relative to professional liability insurance and legislation. Our discussion with the committee included suggested professional liability legislation, as proposed by the American Medical Association Committee on Professional Liability.

RECOMMENDATIONS

- (1) Stimulate the formation of more joint medico-legal committees at county levels.

- (2) Stimulate additional presentations by or under the direction of the Joint Medico-Legal Committee to local bar associations and/or county medical societies.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Physician-Lawyer Liaison as recommended by the Reference Committee.

Ad Hoc Committee to Study Medical Practice Act

HARRISON L. ROGERS, JR., M.D., *Chairman*

Subsequent to the filing of the annual report with the House of Delegates by the Ad Hoc Committee to Study the Medical Practice Act, the Committee held a meet-

ing in Atlanta (4/21/71) to continue its consideration of the matter of establishing a system of "physician's assistants" in Georgia.

The principal purpose of this meeting was to review two legislative drafts written by Mr. Robert C. Kates, associated with the University of Georgia School of Law. Working under a contract between the Office of Comprehensive Health Planning (State Health Department) and the Law School, Mr. Kates had researched Georgia law to determine the nature of legislation that would be necessary for the development of a "physician's assistants" program in Georgia.

In the course of its deliberations the Committee agreed on the following definition of a "physician's assistant":

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant, but not necessary within the presence or under the personal supervision of the physician who employs him."

In addition the Committee recognized that certain problems will exist by reason of the fact that some individuals will in all probability be functioning as "physician's assistants" at the time any legislation which may be approved by the Council could be enacted. Accordingly the Committee does not feel that these people should instantly be "put out of business," but rather feels that some grace period should be accorded them.

Therefore, the Committee agreed that a "grandfather" clause to provide a reasonable length of time during which these people could prepare for such examinations as may be required, should be written into any legislative proposal.

The Committee also reiterated its position that "physician's assistants" should be neither licensed nor certified by the State, although it was agreed that some form of recognition would be necessary to create a presumption of competency on the part of the "assistant."

And finally, the Committee agreed that the draft proposals being prepared by Mr. Kates, reflecting the recommendations of the Committee, would be distributed to all Committee members for its continuing study of this matter.

A full set of all the minutes and the original drafts prepared by Mr. Kates (as well as additional drafts if ready) will be available to the Reference Committee for their review.

It is understood, of course, that any legislation forthcoming on this subject must be approved by the Council prior to adopting an MAG position. I would like to point out, however, that an Interim Committee of the General Assembly is looking into this matter also and your Ad Hoc Committee anticipates working with this Committee in the interest of seeing that the best possible legislative solution will result.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee considered these reports together and recommends approval of the recommendations in Ad Hoc Committee Report 71-25 and recommends approval of Supplemental Report 71-3 with the insertion of the word "always" in line 18 between the words "services" and "under" so that the sentence would read:

"The physician's assistant is a skilled person quali-

fied by academic and practical training to provide patient services always under the supervision and direction of a licensed physician who is responsible for the performance of that assistant, but not necessarily within the presence or under the personal supervision of the physician who employs him."

HOUSE OF DELEGATES ACTION—Rejected the reports of the Ad Hoc Committee to Study the Medical Practice Act, thereby disapproving the recommendations of the Reference Committee.

Medical Review and Negotiating Committee

JOHN R. MCCAIN, M.D., *Chairman*

It is a pleasure for me to submit the following report on the activities of the Committee for 1970-71:

The Committee developed and distributed a policy manual on procedures, legal guidelines, forms, etc. This policy manual was incorporated *in toto* into the AMA manual on Peer Review for national distribution.

The Committee developed processing parameters for third party computer programming, on major problem diagnoses and procedures.

The Committee adopted and promoted through a subcommittee the use of the Proficiency Evaluation Program of the College of American Pathologists as the officially endorsed laboratory evaluation program of MAG.

The Committee developed through a subcommittee recommendations to third parties on the criteria for allowing increases in physicians' fees.

The Committee strengthened through a subcommittee the cooperative relationships between MAG and third parties.

The Committee recommended specific consultants to assist the Medicare Carrier.

Influenced the acceptance, by the State Board of Workmen's Compensation, of the usual, customary or reasonable fee concept and has continued to assist them in the adjudication of problem claims.

The Committee assisted in the formation of the peer review aspects of the Georgia Foundation for Medical Care, Inc., and accepted appointment as peer review component of the Foundation.

The Committee followed closely the progress of national legislation on health insurance, peer review mechanisms, etc.

The Committee reviewed and accepted through a subcommittee the responsibility for advising the staff on its Hospital Utilization Review Demonstration Project, by contract with the U.S. Public Health Service.

The Committee advised third parties and members of specific problems, such as:

Monthly ECF visits and fees.

Use of group PA numbers.

Bedside X-Ray in Nursing Homes.

The Committee recommended to Executive Committee the change in Committee name to the more descriptive and universally recognizable name Peer Review Committee.

The Committee followed the CHAMPUS drug program through a subcommittee and advised the administrator in contacts with the national office.

The Committee negotiated with the carrier and the Bureau of Health Insurance to clarify misunderstandings with regard to completion of claim forms by hospital-based physicians.

The Committee successfully promoted the adoption of the 1970 AMA Current Procedural Terminology as the MAG endorsed system of coding and nomenclature in submitting claims.

The Committee completed all actions referred to the Committee by the House of Delegates, Council, and Executive Committee, including:

Development of guidelines for proficiency testing of physicians' laboratories.

Acceptance of Workmen's Compensation cases for review.

Establish working liaison with third party carriers.

At the direction of my Committee I am including as part of my report the following excellent report of our Subcommittee on Criteria for Increasing Charges:

Critics of medicine generally chart physicians' fee levels against the general cost of living as measured by the Consumer Price Index. Doctors' fees have been going up more than the C.P.I.'s all-items figures since the mid-1950's. However, if physicians' charges are compared to over-all U.S. wage trends, an entirely different picture is obtained. During the past 15 years average earnings in all employment covered by Social Security have increased at a faster rate than physicians' charges. The average annual increase in wages was higher than the average annual increase in physician fees from 1955 to 1965. During the past five years the average annual rise in physicians' fees has been 6.7 per cent as compared to an annual increase of 5.8 per cent in wages.²

At first glance this would appear to place the physician in a favorable financial position in the present economy of this country. Upon further examination of medical costs one finds much evidence to indicate that at least in the past two or three years the cost of doing business for the average physician has increased at a greater rate than wages and at a much greater rate than the cost of living index. A survey by *Medical Economics* showed that in 1968 there was a rise of 11.3 per cent in business costs of the solo practitioner (one specialty had a 19 per cent rise) while the rise in the cost of living was only 4.7 per cent.¹

A similar survey in 1969 showed a 14 per cent rise in business costs for the physician which more than doubled the annual rise of 6.1 per cent in the cost of living index.³ The consumer index for the first nine months of 1970 was 4.0; this indicates that the 1970 annual cost of living rise will be near the 1969 index of 6.1 per cent.³

The biggest three year rises (1966-1969) in professional expense occurred in the South, and the differential in this part of the country is due in great part to the rapid rise in salaries for allied health personnel whose pay was previously less than that in other areas of the country.³

In spite of the increase in business costs, the net earnings of most physicians have managed to keep pace with the rise.³ It is recognized that the physicians' ability to keep pace with these rises in overhead has been made possible by such modalities as hiring additional auxiliary personnel, by applying more efficient practice methods, and especially by spending more hours working. It is the impression of the Committee that most physicians have concentrated upon methods of increasing their efficiency during the recent past and most physicians are working longer hours than ever before. In spite of these efforts, the net income of physicians

will soon begin to suffer unless provision is made for adequate increase in their fees according to some reasonable formula. In fact, there is evidence that this is already beginning to happen.⁴

Based on the above figures and projections for the cost of living, U.S. wage trends, and the physicians' cost of doing business over the past three years, it is the opinion of the Committee that an increase in fees for physicians' services of at least 10 per cent per year since December 31, 1967 is necessary in most fields of medical practice in order for the physician to maintain a new income which will have the same buying power from year to year and thus allow him to sustain his position in the economy. Subsequent annual increases should be based upon the increase in the cost of living, wage trends and the increase in the cost of doing business for the previous year.

References:
1. *Medical Economics*, December 8, 1969, pp. 83-89.
2. *Medical Economics*, October 26, 1970, p. 99.
3. *Medical Economics*, November 23, 1970, pp. 81-99.
4. *Medical Economics*, December 21, 1970, pp. 63-71.

This report is submitted with sincere appreciation to Mr. Smith and the MAG Staff whose hard work has made many of the above accomplishments possible, and with admiration and respect to all the members for their dedication and perseverance.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with the deletion of lines 7 through 9 on Page 1, the insertion of the word “a” in line 27 of Page 1 between the words “as” and “peer,” and by amending line 21 of Page 4 to read “is necessary to the practice of most physicians.” The changes in this report were based on recommendations made by a member of the Medical Review and Negotiating Committee, Edwin C. Evans, M.D.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Medical Review and Negotiating with the amendments recommended by the Reference Committee.

Resolution 71-4
Cessation of Mailing of Unsolicited Drugs

WHITFIELD COUNTY MEDICAL SOCIETY

WHEREAS, there has been much concern over drug abuse recently both by the public and within the medical profession; and

WHEREAS, there seems to be an increasing amount of unsolicited drug samples sent to doctors' offices through the mail; and

WHEREAS, the disposition of these samples of unwanted drugs is the burden and responsibility of the physician and is a potential source for drug abuse; therefore be it

RESOLVED, that the Medical Association of Georgia notify the pharmaceutical companies to cease mailing unsolicited drug samples to its members.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this resolution with the deletion of the word “notify” in line 10 and inserting in its place the word “request”; insert the word “dangerous” after the word



J. G. McDaniel and Mrs. McDaniel at the Annual Banquet of M.A.G.

unsolicited in line 11; delete the words "to its members" in line 12 and insert after the words "samples" in line 12 "as defined by the Bureau of Narcotics and Dangerous Drugs under the Department of Justice," so that it will read as follows:

"RESOLVED, that the Medical Association of Georgia requests the pharmaceutical companies to cease mailing unsolicited dangerous drug samples, as defined by the Bureau of Narcotics and Dangerous Drugs under the Department of Justice."

HOUSE OF DELEGATES ACTION—Delegate Earl T. McGhee moved to amend the **RESOLVED** to read:

"RESOLVED, that the Medical Association of Georgia requests the pharmaceutical companies to cease mailing unsolicited drug samples to physicians of Georgia."

This motion was duly seconded and adopted.

Resolution 71-6

Opposition to Establishment of Health Care Corporations by HEW

LUTHER WOLFF, M.D., *Columbus*

WHEREAS, the Department of Health, Education and Welfare, through the State and District Health Departments, is presently engaged in the establishment and financing of certain closed panel group practice corporations, and

WHEREAS, recently, the Health Department sought the approval of the establishment of such a corporation in Columbus, Ga., which proposal was rejected by the Muscogee County Medical Society on the following general grounds:

(a) That there is no real medical need for such an organization.

(b) That control of such a corporation will not be primarily in the hands of physicians.

(c) That this type of corporation is not in the best medical tradition of this State, in that it infringes upon the free choice of physician and patient; it has not been shown that persons covered under this type of plan are healthier or live longer than others; that such a plan is likely to increase the cost of medical care; and that this type of medical care is considered by many to be an "assembly line" type of medical practice; and

WHEREAS, we do not believe that it is the function

of the Department of Health, Education and Welfare or the Health Department to dictate or control the practice of medicine in Georgia; and

WHEREAS, the solution of medical problems in Georgia can better be solved by working through such medically initiated and controlled plans such as the Georgia Medical Care Foundation, Incorporated; now therefore be it

RESOLVED, that the Medical Association of Georgia go on record as opposing the establishment of health care corporations in Georgia by the Department of Health, Education and Welfare, and that officials of the Department of Health, Education and Welfare, the State Board of Health, and the Director of the State Department of Health and District Health officers be so notified.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee recommends approval of this resolution by amendment of the resolved portion to read as follows:

"RESOLVED, that the Medical Association of Georgia recognizes that we are in an era when new health care delivery systems must be carefully considered. However, government agencies should not undertake the development of health care delivery systems without the joint planning and approval of the Medical Association of Georgia and its component societies; and be it further

"RESOLVED, that the Medical Association of Georgia specifically opposes the attempt of the Office of Comprehensive Health Planning to establish an experimental health care delivery system in the Columbus, Georgia area and that immediate action be taken to rescind this particular application by indicating our position to the appropriate government agencies."

HOUSE OF DELEGATES ACTION—Delegate Jack Raines introduced a motion which would have removed the reference in the **RESOLVED** to a specific city. Following debate the motion was withdrawn.

The House of Delegates adopted Resolution 71-6 with the substitution of the **RESOLVED** portions recommended by the Reference Committee.

Chairman Stubbs then reported that this concluded the report of Reference Committee C and stated that he wished to thank the members of the Reference Committee for their time and effort. Chairman Stubbs then moved adoption of the report as a whole. The motion was duly seconded and approved.

Report of Reference Committee D

Ronald F. Galloway, M.D., *Chairman*

Chairman Galloway reported that the reports and resolutions referred to Reference Committee D had been considered by the Committee which meet at 9:00 a.m., in the Whitehall Suite, Marriott Motor Hotel, Atlanta, on May 15, 1971. Members of the Committee present included: Ronald F. Galloway, M.D., Augusta, Chairman; Billy S. Hardman, M.D., Gainesville, Vice Chairman; William Chambliss, M.D., Hamilton; L. Newton Turk, M.D., Atlanta; Charles T. Cowart, M.D., LaGrange; and S. William Clark, M.D., Waycross.

Vice Speaker, House of Delegates

PRESTON D. ELLINGTON, M.D., *Augusta*

It has again been my privilege to serve this House of Delegates as Vice Speaker this year.

I attended all meetings of Council with one exception and Executive Committee meetings when your Speaker was unable to attend. The Southeastern Speakers' Conference was cancelled this year due to conflicting commitments.

I feel that the innovations we have made have served to facilitate and to expedite the work of this House.

The Delegates' Handbook is mailed out in advance of the Annual Session and your Speaker and I strongly urge each delegate to familiarize himself with all the material in the Handbook prior to the meeting.

Since, in a number of county medical societies there are few practicing physicians and for this reason, among others, often a delegate is unable to leave his practice to attend the Annual Session, many counties often are not represented in the House of Delegates.

At the past five annual meetings three societies have not been represented. Thirteen were represented at only one annual meeting and five societies were represented at only two out of the five meetings. Although the situation has improved since 1966 when only 42 societies were represented, whereas in 1970 there were 51 societies represented, I feel that further improvement might be possible.

RECOMMENDATION

I recommend that Council study this situation and report its findings and recommendations for possibly improving this situation to the 1972 House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of the recommendation in this report with the recommendation that it be referred to Council for study.

HOUSE OF DELEGATES ACTION—Adopted the report of the Vice Speaker of the House of Delegates for referral to the Council as recommended by the Reference Committee.

Annual Session Committee

PRESTON D. ELLINGTON, M.D., *Chairman*

The Committee on Annual Session of the Medical Association of Georgia once again expresses its appreciation to all those members of the Association, the Auxiliary, and the MAG staff for their loyal and dedicated efforts to make these meetings possible. I am deeply indebted to Mr. Edwin Smith, Mrs. Catherine Wooten, and Mr. John Kiser who have spent many hours of work collating the countless details. The Local Arrangements Committee is to be commended for their efforts on behalf of the Annual Session.

This Committee continues to work to improve the meeting. In 1969, the first year of the new format, attendance was 1,007 and last year the attendance was 1,161 and we anticipate an even greater attendance at the 1971 meeting.

Again this year, Special Society activities have been scheduled during the official dates of the Annual Session. We have had an every-member mailing of two

special releases which have given thumb-nail announcements of meeting activities and events. Again this year, we have mailed to every member a pocket-size complete program.

The number of exhibits in the Art Show in its second year more than tripled in the number of entries. The Art Show Committee is to be commended for their diligent efforts.

Thanks to the efforts of Dr. Luther Vinton, Commercial Exhibits chairman, we had the most favorable rating ever received from the exhibitors.

This year, for the first time, the Annual Session of the Medical Association of Georgia will have closed circuit TV programs in each room of the Headquarters' Hotel. The Medical Association of Georgia is one of the very few organizations to have such a feature.

We will continue to strive to present an interesting, educational and informative meeting for our membership. We urge each and every one of you upon your return home to contact those fellow members who do not attend the Annual Session and convince them of its merits and encourage them to attend future meetings of the Medical Association of Georgia.

RECOMMENDATIONS

1. We recommend that the 1976 and 1977 Annual Session be held in Jekyll Island and Macon.

2. Because there is an ever increasing demand for sponsors to subsidize the Social Hour held prior to the Annual Banquet, an increasing difficulty for some of the Host Societies to obtain sponsors and thus create a financial burden on these societies, and that many physicians have expressed the opinion that we should not go outside the medical profession to obtain contributions for a social hour for physicians, we recommend that the Social Hour preceding the Annual Banquet be a responsibility of the Annual Session Committee, financed by MAG.

On behalf of the Committee on Annual Session and the members of the Medical Association, I would like to thank the members of the Fulton County Medical Society for their generous and gracious hospitality as host of the 1971 Annual Session of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report with an amendment in line 23, Page 2,



Mr. Wilbur J. Cohen, Secretary of H.E.W. for 1968-69, participated in the panel on "America-Health Care."

so that it would read “. . . MAG, if desired by the host society.” As an explanation for this change your reference committee was made aware of the possibility of a financial burden being placed on certain host societies. This will enable the Committee on Annual Sessions to take over this responsibility if requested.

HOUSE OF DELEGATES ACTION—Approved the report of the Committee on Annual Session with the amendment as recommended by the Reference Committee.

Woman’s Auxiliary Advisory Committee

S. WILLIAM CLARK, JR., M.D., *Chairman*

As Chairman of the Advisory Committee from the MAG to the Woman’s Auxiliary I have been made very aware that the sole purpose of the auxiliary is to serve the best interests of the medical profession at all levels.

The organized auxiliary and individual doctors’ wives are willing to help us in any way requested and I feel if component medical societies would take the time and effort to look around them in their communities for unmet health needs, then suggest ways the auxiliaries could help to correct a situation, that much good would be accomplished for medicine and for the public health.

During the past year the MAG specifically asked the auxiliary to assist with eye and hearing tests for pre-school children and in preparing a brief history of local medical societies and most of the auxiliaries have been very cooperative.

Mrs. Charles R. Smith, state president, has had excellent programs at the Board Meetings held in May, July and January, which are designed to assist the county president and her local group. The state officers and chairmen have worked diligently to provide local auxiliaries with helpful suggestions. Mrs. Smith has also attended all meetings of the MAG Council which is an important liaison.

RECOMMENDATIONS

(1) Since it takes a great deal of secretarial work on the part of the state president, primarily, to do her job effectively, I recommend that she have *sufficient financial assistance* for this purpose.

(2) Assuming that all doctors’ wives should be members of the Auxiliary, I also recommend that each *county auxiliary bill directly the doctor’s office* for annual dues.

(3) Investigation should be made as to *including the Auxiliary membership in the central billing* handled by the MAG.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves Recommendation (1) with the notation that such financial assistance is provided in the 1971-72 budget; approves Recommendation (2) with the amendment in line 3 on Page 2 by adding the words “be encouraged to” between the words “Auxiliary” and the word “bill.” Your reference committee feels that the House of Delegates would not wish to direct any county auxiliary on its billing method. At the same time your reference committee feels that direct billing of doctors’ offices would increase Auxiliary membership and interest and, therefore, these words are inserted; and approves Recommendation (3).

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman’s Auxiliary Advisory Committee with the amendments as recommended by the Reference Committee.

Maternal and Infant Welfare Committee

EUGENE L. GRIFFIN, M.D., *Chairman*

Under the chairmanship of Dr. Eugene Griffin this committee continued in 1970 to study in detail each maternal death from information obtained. It also concerned itself with other matters pertaining to maternal and infant health in the state of Georgia. Major areas of activity are listed below.

LIVEBIRTHS AND BIRTH RATE

There were 90,198 livebirths in 1969. The birth rate increased to 19.4 (19.1 in 1968). This increase in birth rate was due to an increase of the white livebirth rate from 17.3 in 1968 to 17.8 in 1969. The nonwhite livebirth has decreased slightly in the past year from 24.2 in 1968 to 24.1 in 1969. (Preliminary data indicate that there were approximately 92,000 livebirths in 1970.) Hospital deliveries reached a high of 95.8 per cent compared to a rate of 94.5 per cent in 1968.

MIDWIFE ACTIVITIES

There were 3,179 (3.5 per cent) livebirths attended by midwives in 1969. This represented a decrease of 875 or 21.6 per cent less than the previous year. In 1970, 4,042 hospital deliveries were paid for under Medicaid (Title XIX).

MATERNAL MORTALITIES

There were 29 maternal deaths in Georgia in 1969 out of a total of 90,198 livebirths. The death rate of 3.2 per 10,000 livebirths represented a decrease from the 3.4 rate of 1968. The leading cause continued to be toxemia (6). Pulmonary embolus was the cause of death in five cases, abortion in four, ectopic in three, and infections and hemorrhage each caused one death. Other diseases and conditions during the pregnancy or puerperium were responsible for six deaths, and other accidents or specified conditions during childbirth, three deaths.

IMMATURE BIRTHS

In 1969 there were 8,375 immature livebirths (114 more than in 1968) for a rate of 92.9 per 1,000 livebirths (decrease from 94.6 in 1968). Immaturity at birth is twice as frequent in the nonwhite as in the white race. It is also significant that immaturity occurs more frequently in livebirths to the mother under 18 in both races.

PER CENT OF IMMATURE LIVEBIRTHS—1968-1969		
	1968	1969
White	7.3	7.0
Nonwhite	13.8	14.1
White Under 18	10.9	9.9
White 18 to 39	6.9	6.8
Nonwhite Under 18	17.3	16.3
Nonwhite 18 to 39	13.2	13.7

BIRTHS TO UNWED MOTHERS

There were 10,181 livebirths to unwed mothers, an increase of 135 over the previous year. The rate, however, declined from 115 to 112.9 from 1968 to 1969. Livebirths to white unwed mothers (2,146) increased 34, and livebirths to unwed nonwhite mothers (8,035) increased 101 from the previous year. Immaturity at birth is significantly influenced by marital status both generally and racially.

PER CENT OF IMMATURE LIVEBIRTHS—1968-1969		
	1968	1969
Married	8.8	8.8
Unmarried	14.2	14.4
White Married	7.1	6.8
White Unmarried	11.1	11.4
Nonwhite Married	13.1	13.6
Nonwhite Unmarried	15.0	15.2

LIVEBIRTHS TO GRAND MULTIPARA

A total of 5,661 livebirths (6.3 per cent) in 1969 were in the order of sixth and over. In 1968 there were 6,450 livebirths (7.4 per cent) in the order of sixth or over. Since 1960 the per cent of *first* and *second* births to a mother has been increasing in both races. However, the per cent of births in the order of *third* or *greater* have shown significant declines. In 1968, 41.3 per cent of all white births were in the order of third and greater. In 1969 this had declined to 29.1 per cent. The percentage of third and greater order livebirths among the nonwhite has declined from 60.6 per cent in 1960 to 41.0 per cent in 1969.

ADOLESCENT PREGNANCIES

Livebirths to adolescents representing 19.6 per cent of all livebirths in 1960 have increased to 21.1 per cent of all livebirths in 1969. There were 8,261 livebirths to mothers under 18 years of age out of the total of 20,825 adolescent livebirths. Of the livebirths to unwed mothers 52.4 per cent were to adolescents. One out of every eight infants liveborn to an adolescent is immature by weight at birth.

NUTRITION

All counties have some supplemental type of food program for pregnant mothers. One hundred and thirteen have Food Stamp Programs and 46 have the Surplus Commodity Program. Because of the number of different state and federal agencies involved in the food programs there is a great discrepancy of service to the consumer between various counties in the state.

PERINATAL MORBIDITY AND MORTALITY

Because of the recommendations of the Committee and the Medical Association of Georgia relating to medical information to be obtained with the birth certificate, the Department of Public Health has studied methods of obtaining confidential medical data and will propose the adoption of a new Certificate of Livebirth which will meet the needs for vital registration as well as medical biostatistical analysis. A tentative target date

of January, 1972, has been suggested for the new certificate.

THERAPEUTIC ABORTION

In the Spring of 1970, the House of Delegates of the Medical Association of Georgia authorized the Association's Maternal and Infant Welfare Committee to conduct a survey among physicians in the state. The survey's purpose was to determine current attitudes toward abortion and to determine what type of abortion law would be supported by the Medical Profession.

On September 16, 1970, in accordance with this authorization, the Committee sent questionnaires to 3,263 active members of the Medical Association of Georgia and to 445 inactive members. The inactive category includes associate, affiliate, honorary and service members. By October 12, 1970, 1,869 completed questionnaires from active members and 174 completed questionnaires from inactive members had been returned. This is an overall response of 55.1 per cent. For results of the study see the December 1970, issue of the *Journal-MAG*.

According to records received by the Georgia Department of Public Health, there were 699 therapeutic abortions performed in Georgia in 1970. This was a rate of approximately 7.5 per 1,000 livebirths estimated for the year. In the first eight months (January-August) there were 312 therapeutic abortions performed. In the last four months, after the court opinion liberalizing abortions a total of 387 therapeutic abortions were reported. Four out of every five abortions were to white women. Fifty-two per cent of all therapeutic abortions were performed on women under the age of 25. If we relate the total abortions in 1970 to the total deliveries by five year age groups in 1969, the greatest incidence of therapeutic abortion is in the 10 to 14 year old group with a ratio of 60.4 abortions per 1,000 expected livebirths. The lowest incidence is found in the age group 20-24 with a ratio of 4.6 per 1,000 livebirths. Three out of every four therapeutic abortions done were performed before the end of the twelfth week of gestation. Fifty-six per cent of the women were unmarried at the time of the abortion. Forty-three per cent of the women had no living children. Approximately three out of every four therapeutic abortions were done for reasons of maternal mental health. During the first eight months of the year 80 per cent of all the abortions done were for mental health.

After the announcement of the Federal Court Ruling which did away with the specified indications, thus permitting therapeutic abortions to be done for other reasons, the incidence of maternal mental health as the reason for abortion has fallen to 66 per cent. Social or economic hardship or contraceptive failure was the indication for approximately 20 per cent of the abortions in the last four months of the year.

FAMILY PLANNING

As of December 31, 1970, there were over 36,000 women actively participating in the State Health programs of family planning (1969—27,000). This number is based upon proven continuous active contraceptors by current records in the State data collection computerized evaluation system. The number is on the conservative side, as it does not include a large number of women who received services before the institution

of the current record system and who may well be continuing as active contraceptors. During the calendar year 1970 there were 30,000 admissions to service and a total of 75,000 follow-up visits provided through health department clinics.

CERVICAL CANCER SCREENING PROGRAM

During 1970 the Statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Public Health provided Pap smears to indigent and medically indigent patients receiving health service from local health departments for over 30,000 women. Since the beginning of the program in 1967 approximately 84,000 Pap smears have been done, and 884 women were found to have suspicious or positive Pap smears. Follow-up is completed on 736 of these and a diagnosis of malignancy has been found in 220 cases. Eighty-four per cent of the malignancies were preinvasive carcinoma of the cervix (184), and only 16 per cent (36) were invasive carcinoma of the cervix. Treatment of diagnosed cases has been provided by state assisted tumor clinics and by private physicians.

RECOMMENDATIONS

(1) That the Medical Association of Georgia continue its efforts to see that the new birth certificate containing vital medical information be implemented by the January 1972 deadline.

(2) That the Association encourage that additional Medicaid funds be made available for childbirth, sterilization and therapeutic abortion, especially in the colored indigent.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves and commends this committee for this report. With regard to Recommendation (1), the reference committee was pleased to learn from the Chairman of the Committee on Maternal and Infant Welfare that this new birth certificate containing vital medical information will likely be implemented in the near future. Your reference committee recommends that Recommendation (2) be amended by: (1) placing a comma after the word "abortion" in line 8 on Page 6; and (2) deleting the words "especially in the colored indigent" in lines 8 and 9, on Page 6; and (3) adding "and that the Medicaid policies in this regard be both liberalized and clarified." Your reference committee recommends that the House of Delegates encourage and support the Committee on Maternal and Infant Welfare in its efforts to carry out the goals outlined in its report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Maternal and Infant Welfare with the amendments as recommended by the Reference Committee.

Nursing Liaison Committee

CHARLES EBERHART, M.D., *Chairman*

In 1969 this Committee was charged with the responsibility of investigating present nursing school curricula and evaluating the practicality and effectiveness of producing diplomates skilled in personal patient care.

There is a growing concern among physicians as to the competence of current graduates of nursing schools in regard to "personal nursing care" or "bedside nursing." A number of interviews with physicians reflect a general observation that graduates from nursing schools, whether diploma, associate degree or baccalaureate degree schools, are increasingly deficient in their ability to render good personal patient care at the time they finish school. This opinion is also shared by many graduate nurses in the capacity of floor supervisors who have expressed this same feeling concerning current graduates of nursing schools. It is the opinion of most of those interviewed that this is related to the increasing amount of didactic or classroom education and a decreasing amount of bedside nursing, patient contact, or "floor" training. Of the graduates of the various types of nursing schools, the diploma schools or hospital associated schools seem to provide the best training in this respect. Of the doctors and graduate nurses who were interviewed there was only a very limited experience with associate degree graduates. The information that could be obtained regarding these, however, indicated a very real lack in ability to render good "bedside nursing."

Interviews with those nurses in teaching capacities in nursing schools reflect what is apparently the consensus among the faculties of nursing schools that "personal nursing care" generally must be the product of an orientation course or in-service training by the hospital or facility at which the nurse is employed rather than the responsibility of the school. It was the opinion of most physicians and those responsible for nursing service that the majority of hospitals are incapable of offering adequate training to provide this educational need.

There is a decided trend toward associate degree nurse training in large part at the expense of the diploma school training which has suffered a marked attrition in recent years. While the need for nursing personnel is great and demands the utilization of all types of nursing training including associate degree nursing, the loss of the diploma school nurse would seem an intolerable blow in terms of loss of total nursing personnel as well as the loss of that nurse who is best equipped to provide "personal nursing care."

There is apparently considerable variation in the curricula of the various associate degree programs and much of the training is in "observation" roles. It is difficult to prescribe an effective extension to the training in terms of "bedside nursing" under these circumstances.

While no difficulty was encountered in frank and forthright discussion with individual members of the nursing profession in all areas including nursing education, nursing service, staff nurses in hospitals, public health nurses, it was quite difficult to develop communication and dialogue with any group of nurses who could represent and speak for nurses as a whole. Nursing organizations represent a fragmented and ineffective representation of the nursing profession. This is one of the great weaknesses in accomplishing any improvement in nursing education and care.

After due consideration the Committee is in agreement with the following conclusions:

(1) There is a great need for nurses of all types, baccalaureate, diploma and associate degree (there is



J. G. McDaniel, M.D. and Henry M. Finch, M.D. ponder the items before the House of Delegates.

quite obviously a need for practical nursing and nursing technicians which is another problem again).

(2) It is apparently a fairly universal observation by physicians that current nursing school curricula do not provide training for optimal "personal nursing care" competency by the graduate.

(3) Current programs and ideas for providing "orientation" courses or "in service training" to compensate for this are inadequate at the present.

(4) Because of the above (2 and 3) there is a need in nursing care which is not being met. This requires either a re-evaluation and improvement of current nursing education or a restructuring of the pattern of nursing care to accommodate for the new role of the R.N. and replacement of her historical role in nursing care by other personnel.

(5) Both the standardization of curricula and a standardized program for "bedside nursing" training for the associate degree program is needed.

(6) The baccalaureate degree nurse whose principal area of activity is apparently designed to be in teaching and administration needs more "bedside nursing" orientation to provide adequate instructions for trainees.

(7) Diploma schools should be given every encouragement, professionally and financially, to continue to maintain their responsibility in the training of nurses.

(8) A definite program of liaison between nurses and physicians representing groups who have authority to take action or make recommendations that will result in specific action should be developed.

RECOMMENDATION

In answer to Resolution 69-5 referred to the MAG Committee on Nursing Liaison, the Committee recommends that the House of Delegates consider whether or not an in-depth study should be made by an organization equipped to make this investigation.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee was made aware of a newly appointed MAG committee, the Committee on Education, which has been assigned the task of studying the problems referred to in this report. Your reference committee, therefore, recommends that this report be approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Nursing Liaison as recommended by the Reference Committee.

Resolution 71-1

Delegates' Handbooks to Alternate Delegates

RICHMOND COUNTY MEDICAL SOCIETY

WHEREAS, thorough understanding of matters to come before the House of Delegates by Alternate Delegates serving as Delegates (as well as Delegates themselves) is desirable; and

WHEREAS, the Delegates' Handbook represents as complete a summary of such matters as exists; therefore be it

RESOLVED, that copies of the Delegates' Handbook be mailed in advance of Annual Sessions to all Alternate Delegates as well as those Delegates who now receive the handbooks.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee agrees with the intent of this resolution. Your reference committee, therefore, offers a substitute resolution to read "RESOLVED that copies of the Delegates' Handbook be mailed to Alternate Delegates whose county societies request them no later than three months prior to the Annual Session, as well as to those Delegates who now receive the Handbooks."

HOUSE OF DELEGATES ACTION—Adopted Resolution 71-1 with the substitute RESOLVED as recommended by the Reference Committee.

President-Elect's Address

W. C. MITCHELL, M.D., *Smyrna*

Mr. President, members of the Medical Association of Georgia, members of the Medical Auxiliary, and Distinguished Guests:

This is indeed a high honor that has been bestowed upon me, and I want you to know that I feel most humble and deeply appreciative to have been chosen to serve as President during the coming year. Little did I realize, when I first became a member of this organization 38 years ago, during the presidency of Dr. Charles Richardson, that I would be standing here today. Following presidents of the caliber of Tex Eldridge, Kirk Train, Charlie Andrews, John Mauldin, Walter Brown, George Alexander, J. G. McDaniel, and all those back to Dr. Charlie Richardson's time, causes me to feel a little apprehensive of being able to carry

on in the image that they have so nobly carved into our organization. Someone, knowing the job that lies ahead of me, asked if I had lost any sleep just thinking about it. My reply to this was: "No, I was sleeping like a baby—waking up every three hours screaming out loud."

I know I could never fill the giant shoes of my predecessors, but being the giants that they were, I'm going to try standing on their good strong shoulders and give it my very best.

When I first began practice, nearly 40 years ago, it was necessary for Doctors to make house calls. Everyone didn't have an automobile—there were not many ambulances, and very few telephones. The belief at that time was widely held that a sick person shouldn't get out from under the quilt. Doctors in those days were comforting, reassuring, and unhurried—and for good reason. Comfort and reassurance were about all we had to offer. The sulfas came along in the late thirties, followed by penicillin in the forties, and then came the whole range of chemotherapeutic aids and antibiotics. Today Doctors have at their command the tools of electronics, biochemistry, nuclear physics, and the mass array of drugs coming from continuing pharmaceutical research. The fact that we can do so much more and see so many more patients is in itself frustrating both to the patient and to the Doctor, and with this scientific revolution which began gathering momentum some 20 years ago, there came an ever-widening gap between the public and the health care teams.

Today, medicine is being challenged as never before, with so many changes taking place, we have not only the problem of keeping up with the new, but trying to sort out the good in both the old and the new. These changes do affect us all, and how we handle them will determine whether we end the decade of the seventies with a vibrant living organization, or with something that will exist only in our memories. We will have to excel in planning, decision-making, in formulating and executing the whole strategy or game plan. We will need insight into the nature and mix of the political, economic, and social forces of our society. These are all moving and changing forces and they are not susceptible to any fixed formula or to any preconceived solutions. Our judgments must be peripheral, with a vision as steady and sweeping as the scope of a radar screen constantly registering the forces and trends about us.

Our future depends on how well we keep up with all these changes and tailor our services to be more effective. Thinking first, last and always of what's best for our patients—always keeping in mind—we are what we are—as individuals and as an Association, in order to serve the people who come to us with need. And we want these services to be the very best—of the highest quality—and provided at the most reasonable cost possible.

In order to do a better job, we should be freed of restrictive regulations that do not affect the safety and health care of our patients. Government constraints that distort the normal workings only impair the ability of the physician to function properly and are of no value to either the patient or his Doctor. Regulatory decisions, once made and implemented, appear to be impervious to change even when they have become obsolete by their own standards.

The communications gap, as we all know, is real and large. It could be because we spend too much time telling ourselves what we want to hear. This results in a satisfying sense of agreement among ourselves, but very little communicating to others of the principles and values that we agree on. Our legislators, for example, have as good grounds for complaining about our grasp of their business as we have of complaining about their grasp of ours. We need to develop an informed, positive approach to the political process. We need to understand and appreciate the problems that health care issues present to those who bear the burdens of legislation.



Irving Hellenga, M.D., and Charles Cowart, M.D., participate in the deliberations of the House.

We are heading for more dynamic exciting days. We neither expect, nor do we want, a slowing of the pace of change or a lowering of the level of the challenge that change has brought about. But we must ask for a fair opportunity to meet the challenge in a way that is at least a little consistent with the traditions of a free practice of medicine and in a free society that has confidence in our capacity to make correct and responsible decisions—and with the right to be judged accordingly.

RECOMMENDATIONS

With these thoughts in mind, it is my recommendation:

- (1) That we strengthen our public relations both in means and methods.
- (2) That we give all support possible to GaMPAC and AMPAC.
- (3) That we offer our services and help to our political community, in an effort to keep them from getting so frustrated in health care matters. We know there are gaps to close and bridges to cross. We would like to help keep some of them from running off these bridges.
- (4) We should get more involved in the socio-economic field. In matters of drug abuse, alcoholism, mental health, aging, pollution, education, public health, and civic club endeavors, to mention just a few.
- (5) Continue to support and solicit the help of our woman's auxiliary, for we know that generally speaking, our ladies are "Generally speaking" for us.
- (6) Strengthen and get more members familiar with the Foundation program for peer review.

(7) We must give thought and make plans for a change in our dues structure which is the lowest in the nation (\$40.00), compared to Alaska's \$200.00 per year which is the highest. We should be somewhere in between these two extremes. One of the sub-rosa practitioner groups that attempts to be part of the health care program, and a group that costs us the most in time, energy, and money in fighting their bills in the legislature, has dues of \$500.00 per annum, and this is supplemented with frequent assessments as the need arises. It has only been through the efforts of a frugal house, the wise planning of our budget committee, the foresight of those who helped in getting the several government programs housed in our building, and the untiring efforts of those who work on our multitude of committees contributing their time and travel costs freely without any thought of remuneration, that we have been able to do the many things we have done at so low a cost to the membership.

Many things could happen to change all these favorable situations, and it is high time we took steps to insure ourselves of being able to finance needed programs in the foreseeable future.

(8) Due to the economics of the times, and the over-utilization of the profession, it has been easy for charlatans and perpetrators of frauds to take advantage of a public that is seeking medical help. There are, I am sorry to say, a very, very small number of these who are members of our organization, and who use their membership as a shield to give legality and respectability to their nefarious operations. These were accepted as members because they had the necessary qualifications and recommendations. Once members, there is very little we can do to purge them from our rolls. Considering the old cliché of the one rotten apple in a barrel, we should find some means in either our own constitution or by state legislation to correct this situation.

(9) The paramedical groups need our continuous support and in this time of shortages even more so. A new group, the Medex (or physician's assistants) are on the verge of coming into their own. We feel there is a definite need for this type of help. It will be most welcome, but careful plans for training and supervision must be formulated in order for this to add strength to the overall health care program. We must never use the excuse of pressure and unavailability to allow ourselves to surrender to mediocrity.



John P. Heard, M.D., Mr. Edwin F. Smith and Mr. James M. Moffett enjoy a few moments of calm during a hectic day.

With the efficient headquarters staff, the dedication of the House of Delegates, the members of Council, the hard working committees, and believing the membership as a whole stands ready to pitch in and help, and if the good Lord will give us the strength to accept that which we cannot change, and the needed help to change that which is not acceptable, I know the upcoming year will be a success and the Medical Association of Georgia will meet the challenge.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee approves the President-Elect's Speech in its entirety.

HOUSE OF DELEGATES ACTION—Approved the President-Elect's Address in its entirety as recommended by the Reference Committee.

Supplemental Report 71-6 Chairman of Council

MAG COUNCIL

A report was presented to the Council by the Executive Director on his preliminary investigation into further expansion of the MAG Headquarters office building. This report included two projected stages of construction as follows:

(1) Two additional stories of approximately 24,000 square feet including removal of the two-story front wing, installation of elevators, reasonable landscaping and pre-cast stone exterior on all floors.

- Construction time, one year
- Guaranteed maximum cost, \$609,860.00
- Architect's fee, 8 per cent
- Loan expenses, approximately 4 per cent
- Construction cost approximately \$27.00 per square foot

(2) Four additional stories of approximately 40,000 square feet including items listed in alternative (1).

- Guaranteed maximum cost, \$1,089,376.00.



Robert D. Waller, M.D., J. Harold Harrison, M.D. and John T. Godwin, M.D., pause to pose while touring the commercial exhibits.

RECOMMENDATION

Council voted to ask the House of Delegates to authorize the Council to proceed with expansion of the Headquarters Building based on a favorable feasibility study.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Approved

Supplemental Report 71-6 of the Council as recommended by the Reference Committee.

Supplemental Report 71-7
Budget for Fiscal 1971-72

C. E. BOHLER, M.D., *Chairman of Council*

The attached budget for fiscal year June 1, 1971-May 31, 1972, as adopted by Council May 12, 1971, is referred to the House of Delegates for endorsement.

SUMMARY-COMPARISON OF BUDGETED AND ACTUAL OPERATIONS
THE MEDICAL ASSOCIATION OF GEORGIA
Period June 1, 1970 to April 30, 1971

	<i>Budget</i> <i>6/1/70</i> <i>5/31/71</i>	<i>Actual</i> <i>6/1/70</i> <i>4/30/71</i>	<i>(Over)</i> <i>Under</i> <i>Budget</i>	<i>Proposed</i> <i>Budget</i>
INCOME				
I. (a) MAG Dues	\$126,000.00	\$137,440.00	\$(11,440.00)	\$126,000.00
(b) Int. & AMA	9,500.00	19,981.65	(10,481.65)	9,500.00
(c) GP Service	3,250.00	2,708.30	541.70	3,250.00
(d) Additional Dues		11,100.00	(11,100.00)	
(e) Parking		4,240.00	(4,240.00)	6,000.00
II. ANNUAL SESSION	8,000.00	6,700.00	1,300.00	8,000.00
III. JOURNAL	40,000.00	37,909.80	2,090.20	40,000.00
IV. CONTINGENT				
Trans. fr. Opr. Cap. to Cont.	10,000.00		10,000.00	
Trans. from Add'l Dues	54,495.00		54,495.00	
Trans. from Dep. Fund	6,000.00		6,000.00	
Trans. from Opr. Cap.	104,853.43		104,853.43	198,391.25
	\$362,098.43	\$200,079.75	\$142,018.68	\$391,141.25
EXPENSES				
I. (a) Fixed Allot.	\$ 98,518.43	\$ 89,586.42	\$ 8,932.01	\$ 99,236.75
(b) Assoc. Office	147,890.00	102,844.43	45,045.57	152,371.82
(c) Assoc. Comm.	38,410.00	15,019.87	23,390.13	55,870.00
(d) Related MAG Act.	2,875.00	1,925.00	950.00	3,425.00
(e) Ex. Com. Dis. Fund	1,000.00	270.29	729.71	1,000.00
(f) Cont.-Trans. from Oper. Cap.	10,000.00	4,475.07	5,524.93	10,000.00
II. JOURNAL	48,105.00	46,532.29	1,572.71	53,937.68
III. DEPRECIATION				
Building	15,000.00		15,000.00	15,000.00
Equipment	300.00		300.00	300.00
	\$362,098.43	\$260,653.37	\$101,445.06	\$391,141.25
LIQUID FUNDS AVAILABLE				
I. C & S Checking	\$ 19,728.08			
C & S Certificates	250,000.00			
C & S Certificates	50,000.00			
Includes the following Restricted Funds:				
Equipment Dep.	\$ 3,153.49			
Building Dep.	34,600.00			

BUDGETED AND ACTUAL OPERATIONS

I. (a) FIXED ALLOTMENTS				
Prin. & Int. on Mort.	\$ 54,495.00	\$ 49,953.75	\$ 4,541.25	\$ 54,495.00
MAG Atty. Expenses	700.00	266.34	433.66	700.00
MAG Retainer	4,800.00	4,000.00	800.00	7,200.00
Pension Payments	600.00	600.00		
Pres. Honorarium	2,400.00	2,400.00		2,400.00
Annual Audit	2,000.00		2,000.00	2,500.00
Taxes	15,750.00	15,750.00		17,817.13

	<i>Budget</i> 6/1/70 5/31/71	<i>Actual</i> 6/1/70 4/30/71	<i>(Over)</i> <i>Under</i> <i>Budget</i>	<i>Proposed</i> <i>Budget</i>
Retirement Cont.	14,723.43	14,531.10	192.33	9,624.62
Retirement Trust. Fee	200.00	152.61	47.39	200.00
Woman's Auxiliary	2,850.00	1,932.62	917.38	4,300.00
	<u>\$ 98,518.43</u>	<u>\$ 89,586.42</u>	<u>\$ 8,932.01</u>	<u>\$ 99,236.75</u>
(b) ASSOCIATION OFFICE				
Salaries	\$132,360.00	\$103,230.15	\$ 29,129.85	\$143,400.00
Ins. & Bonds	4,000.00	3,313.16	686.84	9,000.00
Payroll Tax	5,500.00	3,760.13	1,739.87	6,551.82
	+600.00			
Travel—President	1,500.00	2,063.74	36.26	2,000.00
Travel—Pres. Elect	1,000.00	384.88	615.12	800.00
	-558.50	+441.50		
Travel—Past Pres.	1,000.00	441.50		800.00
	+808.50			
Travel—Office	5,000.00	5,345.83	462.67	6,000.00
Travel—Del. & Sec., AMA	3,675.00			
Annual & Clin.	4,225.00	2,674.17	1,000.83	4,000.00
	-550.00			
Travel—Alt. Delegates	3,550.00	1,127.63	2,422.37	3,500.00
Travel—Speakers	300.00			
	-300.00			
Maintenance				
Building	2,750.00	2,326.00	424.00	2,750.00
Equipment	800.00	527.32	272.68	800.00
Tel. & Tel.	4,000.00	3,860.69	139.04	4,500.00
Postage	5,000.00	3,865.11	1,134.89	6,000.00
Office Supplies	5,500.00	5,360.99	139.01	6,000.00
Jan. Serv., Supp. & Sec.	7,700.00	7,037.26	662.74	8,800.00
Meetings	1,850.00	941.08	908.92	2,000.00
Dues & Sub.	455.00	425.00	30.00	470.00
Heat, light, water & AC	8,000.00	7,310.75	689.25	8,800.00
Sundry	200.00	133.41	66.59	200.00
Added Space	4,000.00	4,000.00		
Equipment	8,200.00	7,534.09	665.91	1,000.00
	<u>\$206,890.00</u>	<u>\$165,663.16</u>	<u>\$ 41,226.84</u>	<u>\$217,371.82</u>
Reimbursable Expen.	59,000.00	62,818.73	(3,818.73)	65,000.00
	<u>\$147,890.00</u>	<u>\$102,844.43</u>	<u>\$ 45,045.57</u>	<u>\$152,371.82</u>
(c) ASSOCIATION COMMITTEES				
Annual Session	\$ 10,825.00	\$ 3,119.78	\$ 7,705.22	\$ 16,350.00
Professional Conduct	510.00	197.87	312.13	590.00
Emergency Med. Serv.	450.00	14.85	435.15	700.00
Dis. Med. Care	50.00		50.00	
<i>Special</i>				
Awards	400.00	84.92	315.08	280.00
Blood Banks	25.00	25.00		25.00
Cancer	200.00		200.00	500.00
Crippled Children	50.00		50.00	50.00
Ecological Health	325.00		325.00	600.00
Education	1,400.00	1,068.64	331.36	2,075.00
Nursing Liaison	50.00		50.00	
Allied Health Careers	325.00	132.70	192.30	
Govern. Prog. & Med. Serv.				1,200.00
Areawide Health Plan.	50.00		50.00	
Govern. Med. Serv. (Disbanded)	50.00		50.00	
Historical	50.00		50.00	50.00
Insurance & Economics	1,225.00	761.18	463.82	1,400.00
Legislation	3,900.00	2,874.53	1,025.47	3,600.00
Mat. & Inf. Welfare	850.00	717.98	132.02	150.00
Medicine & Religion	50.00		50.00	50.00

	<i>Budget</i> 6/1/70 5/31/71	<i>Actual</i> 6/1/70 4/30/71	<i>(Over)</i> <i>Under</i> <i>Budget</i>	<i>Proposed</i> <i>Budget</i>
Mental Health	450.00	275.00	175.00	600.00
Occupational Health	625.00	470.98	154.02	475.00
Peer Review	675.00	628.76	46.24	1,250.00
Physician-Lawyer Lia.	50.00		50.00	50.00
Public Relations	1,760.00	1,384.84	375.16	3,550.00
Private Practice	50.00		50.00	50.00
Hosp. Act.	50.00		50.00	
Quackery	10,150.00	844.14	9,305.86	17,000.00
Rural Health	940.00	430.38	509.62	1,450.00
School Child Health	1,000.00	488.32	511.68	2,000.00
Talmadge Hosp. Lia.	50.00		50.00	
Cont. to GaMPAC	1,500.00	1,500.00		1,500.00
Woman's Aux. Adv. (AMA-ERF) ..	325.00		325.00	325.00
	<u>\$38,410.00</u>	<u>\$ 15,019.87</u>	<u>\$ 23,390.13</u>	<u>\$ 55,870.00</u>

(d) **RELATED MAG ACTIVITIES**

AMA Delegates	\$ 1,800.00	\$1,000.00		\$ 2,200.00
Interprof. Council	125.00	125.00		125.00
SMEB (See Cont.)				150.00
SAMA	500.00		500.00	500.00
SAMA-MAG Ann. Sess.	450.00		450.00	450.00

	<u>\$ 2,875.00</u>	<u>\$ 1,925.00</u>	<u>\$ 950.00</u>	<u>\$ 3,425.00</u>
	\$ 1,000.00			\$ 1,000.00

(e) **EXEC. COMM. DIS. FUND**

S. E. Reg. Phy. Ft. Conf.		130.29		
Cassette Cart.		140.00		

	<u>\$ 1,000.00</u>	<u>\$ 270.29</u>	<u>\$ 729.71</u>	
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(f) **CONTINGENT—Trans.
from Operating Cap.**

SMEB	\$ 10,000.00	\$ 120.75		\$ 10,000.00
Atty. Fees		2,000.00		
Files—CHAMPUS		554.19		
Termite Control		275.50		
Med. Review & Nego.		300.00		
Taxes		1,176.16		
AMA Meetings		48.47		

	<u>\$ 10,000.00</u>	<u>\$ 4,475.07</u>	<u>\$ 5,524.93</u>	<u>\$ 10,000.00</u>
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II. JOURNAL

Printing	\$ 34,000.00	\$ 34,230.35	\$ (230.35)	\$ 38,325.00
Salaries	9,180.00	8,415.00	765.00	9,645.00
Insurance	345.00	362.05	(17.05)	937.68
Payroll Tax	550.00	525.68	24.32	700.00
Engraving & Cuts	2,400.00	1,586.13	813.87	2,400.00
Postage & Copyright	1,200.00	1,123.79	76.21	1,500.00
Clipping Service	180.00	139.40	40.60	180.00
Add. & Supplies	200.00	149.89	50.11	200.00
Sundry	50.00		50.00	50.00
	<u>\$48,105.00</u>	<u>\$ 46,532.29</u>	<u>\$ 1,572.71</u>	<u>\$ 53,937.68</u>

Old Business
Association Annual Dues

HARRISON L. ROGERS, JR., M.D., *Speaker*

RESOLVED FROM REFERENCE
COMMITTEE B, 1970

RESOLVED, that this House approve an increase
in the Association's annual dues to \$75 effective Jan-

uary 1, 1971, and urge all committees and divisions of
the Association to carry out their activities to the fullest
within budgeted limitations.

HOUSE ACTION—The House tabled the (third)
RESOLVED until the next meeting of the House.

REFERENCE COMMITTEE RECOMMENDATION
—Your reference committee notes that since June 1,
1970, actual Association expenses have exceeded in-

come by over \$40,000. Your reference committee is further aware that since a dues increase from \$25.00 to \$40.00, which occurred in 1958, there has been no additional increase in annual dues with the exception of the \$100.00 levied by the House of Delegates in 1969. Your reference committee was especially concerned with the fact that the proposed budget for 1971-72 exceeds potential income by \$198,000. Your reference committee was advised by a representative of its auditing firm, Ernst and Ernst, that in order to remain financially sound this organization should retain three to six months operating expenses in reserve which, in this case, would amount to \$100,000 to \$200,000. Your reference committee feels that the House of Delegates should be made aware of the fact that we have incurred expenses in excess of income consistently for the past several years. Your reference committee feels that present Association income from dues will not allow necessary budget increases in the future. Your reference committee feels that the 1971-72 budget can be approved only if there is an increase in dues. Therefore, your reference committee recommends that annual dues be increased to \$100.00 effective January 1, 1972, and that the 1971-72 budget, as distributed, then be approved.

HOUSE OF DELEGATES ACTION—Delegate William W. Moore, Jr., Fulton County Medical Society, moved to amend Supplemental Report 71-7 by addition of the following resolution:

WHEREAS, Council has acted responsibly in deciding the merits of budgetary requests; and

WHEREAS, the House of Delegates has acted responsibly in rejecting and/or denying dues changes—usually for lack of adequate preliminary information; and

WHEREAS, results have been near disastrous, now therefore be it

RESOLVED, that Supplemental Report 71-7 be amended by addition of recommendation that the President appoint a Committee to study, develop and bring to the 1972 House of Delegates a plan for ongoing financing of MAG—which would provide mechanisms to maintain a balanced budget.

Delegate Moore's proposed amendment to Supplemental Report 71-7 was duly seconded and adopted.

Delegate F. William Dowda suggested that the Committee described in the resolution just adopted be appointed at least three months prior to the May 1972 meeting of the House of Delegates.

Delegate C. D. Hollis suggested that State and County leaders prepare an education campaign based on recent actions in behalf of the membership.

Delegate Robert Wells, Fulton County Medical Society, moved to amend the recommendation of the Reference Committee to limit the increase in annual dues making the annual dues \$75.00, effective January 1, 1972. This motion was duly seconded, but failed.

Delegate Jack Raines, Muscogee County Medical Society, then moved that the President appoint, with the advice and consent of the Finance Committee, sufficient members familiar with the budget of MAG to provide speakers for any local societies which might wish to devote a society meeting to a discus-

sion of MAG's dues and budget. This motion was duly seconded and adopted.

The House of Delegates then adopted Supplemental Report 71-7 as recommended by the Reference Committee and amended by resolution from the floor, and adopted the old business as amended by the Reference Committee.

Chairman Galloway then reported that this concluded the report of Reference Committee D and thanked the members of his Committee for their work on the preparation of the report. Chairman Galloway then moved that the Reference Committee report be adopted as a whole. This motion was duly seconded and approved.

Delegate C. J. Roper then moved that the House of Delegates appoint a Parliamentarian. This resolution was duly seconded, but failed.

Speaker Rogers called for further unfinished business, and there being none, he opened the floor for new business, advising the House that new business would be received for information only, as no action could be taken by the House except on business of an emergency nature which would require a unanimous vote for introduction.

There being no further new business, Speaker Rogers then thanked every member of the Reference Committees for their diligent work and the entire MAG office staff for their assistance, and entertained a motion for adjournment of the Second Session of the MAG House of Delegates meeting in conjunction with the 117th Annual Session of the Medical Association of Georgia. On motion duly made and seconded, the House was adjourned and the meeting turned back over to President Eldridge for the continuation of the Second General Session of the MAG General Session.



Outgoing President F. G. Eldridge, M.D. (r.), turns the gavel of office over to incoming President W. C. Mitchell, M.D., during festivities at the Annual Banquet.

MAG Second General Session (Reconvened)

117th Annual Session of the Medical Association of Georgia

Sunday, May 16, 1971

PRESIDENT ELDRIDGE then reconvened the Second Session of the 117th Annual Session of the Medical Association of Georgia and expressed appreciation to Dr. Harrison L. Rogers and Preston D. Ellington for their efficient manner in presiding over the 1971 House of Delegates.

President Eldridge then called for the drawing of the winner of the Exhibit Attendance Prize. Dr. Eldridge asked President-Elect Mitchell to assist as Treasurer John S. Atwater drew an attendance card. He then announced the winner, Dr. L. L. Freeman, of DeKalb County. Dr. Freeman was presented with a portable television as the Exhibit Attendance Prize.

Installation of Officers

President Eldridge then asked the Incoming President, the Officers, the AMA Delegates and Alternates, the Councilors and Vice Councilors to please assemble in front of the Speaker's platform for the installation of Officers as follows:

President—W. C. Mitchell, *Smyrna* (1972)
President-Elect—F. William Dowda, *Atlanta* (1972)
Immediate Past President—F. G. Eldridge, *Valdosta* (1972)

First Vice President—Henry D. Scoggins, *Augusta* (1972)

Second Vice President—Braswell E. Collins, *Macon* (1972)

First District Vice Councilor—Albert M. Deal, *Statesboro* (1973)

Sixth District Councilor—Norman P. Gardner, *Thomaston* (1974)

Sixth District Vice Councilor—W. E. Barron, Jr., *Newnan* (1974)

Seventh District Councilor—David A. Wells, *Dalton* (1974)

Seventh District Vice Councilor—Don Schmidt, *Cedartown* (1974)

Eighth District Councilor—Robert E. Perry, *Brunswick* (1974)

Eighth District Vice Councilor—Joe C. Stubbs, *Valdosta* (1974)

Cobb County Councilor—Remer Y. Clark, *Marietta* (1972)

Cobb County Vice Councilor—Charles R. Underwood, *Marietta* (1972)

DeKalb County Councilor—M. Freeman Simmons, *Decatur* (1972)

DeKalb County Vice Councilor—L. C. Buchanan, *Decatur* (1972)

Fulton County Councilor—John T. Godwin, *Atlanta* (1974)

Fulton County Vice Councilor—J. Norman Berry, *Sandy Springs* (1974)

Muscogee County Councilor—Jack A. Raines, *Columbus* (1974)

Muscogee County Vice Councilor—Louis A. Hazouri, *Columbus* (1974)

AMA Delegate—J. W. Chambers, *LaGrange* (December 31, 1973)

AMA Delegate—John S. Atwater, *Atlanta* (December 31, 1973)

AMA Alternate Delegate—F. G. Eldridge, *Valdosta* (December 31, 1973)

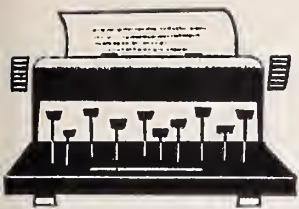
AMA Alternate Delegate—Henry S. Jennings, *Gainesville* (December 31, 1973)

Secretary J. Rhodes Haverty administered the oath of office to the assembled new officers of MAG and declared each of these new officers duly installed. President Eldridge then turned the gavel of leadership over to Incoming President W. C. Mitchell, who expressed his appreciation to those present for the honor of being selected President for 1971-72. President Mitchell then presented to outgoing President Eldridge the President's Key and a bound volume containing the issues of the *Journal of the Medical Association of Georgia* published during Dr. Eldridge's term as President.

President Mitchell then announced that the official attendance at the 117th Annual Session of the Medical Association of Georgia held in Atlanta, Ga., May 13-16, 1971 was as follows:

MAG Members—648; Guests—229; Exhibitors—201; Auxiliary—270; thereby making a grand total of 1,348 registered.

President Mitchell then announced that the new MAG Council and Executive Committee would hold their Organizational Meetings immediately and then entertained a motion for adjournment of the 117th Annual Session. Adjournment occurred at 2:15 p.m.



F. W. Dowda of Atlanta Installed as President-Elect

FREDERICK WILLIAM DOWDA, specialist in Internal Medicine practicing in Atlanta, was installed as President-Elect of the Medical Association of Georgia at the Association's 117th Annual Session at the Marriott Motor Hotel in Atlanta, May 13-16.

Dr. Dowda, born near Smyrna, Ga., in 1926, graduated Phi Beta Kappa with a B.S. degree from Emory University School of Arts and Sciences in 1945 and received his M.D. degree from Emory University School of Medicine in 1949. He completed his postgraduate work at Peter Bent Brigham Hospital in Boston and at Barnes Hospital in St. Louis. Dr. Dowda served in the U. S. Navy during the Korean War, entering the private practice of medicine in Atlanta in 1954.

Dr. Dowda is an active member of the Northside United Methodist Church, where he has served as Superintendent of the Adult Division of Sunday School and as President of Northside's Bible Class. He is a Trustee of the Sandy Springs Planning Council, Chairman of the Fourth Quadrant Civic Association, Chairman of the Health Technical Advisory Committee for Atlanta's Model Cities Program and belongs to the Atlanta Chamber of Commerce.

He has also expressed an avid interest in politics through his participation in the Republican party at the local, state and national level. He serves as the Chairman of the party's Fifth District.

Dr. Dowda's professional society memberships include: Metropolitan Atlanta Medical Association; Medical Association of Georgia; American Medical Association and the Georgia and American Societies of Internal Medicine. He is a fellow of the American College of Physicians and a Diplomate of the American Board of Internal Medicine. He has held the offices of Secretary and President of the Fulton County Medical Society, President of the Georgia Society of Internal Medicine and Vice-President of the Medical Association of Georgia. Dr. Dowda is the President and Chairman of the Board of Directors of the Georgia Medical Care Foundation.

Dr. Dowda is married to the former Elizabeth Harvard. They have three children: Laidler, who will be entering Wake Forest University this fall; Julia, and a son, Hugh, who attends Pace Academy in Atlanta.

Highlights of the 1971 MAG Annual Session

THE 117TH ANNUAL SESSION of the Medical Association of Georgia was convened in Atlanta on May 13-16, 1971. Registration exceeded 1,300 and attendance at all meetings generally, including the House of Delegates, was well-attended by physicians and others from all parts of the State.

Golf and tennis tournaments, the "Medical Mile" and the second annual MAG Art Show highlighted the "extracurricular" activities of the four-day convention.

A full scientific program was offered. Two programs of general interest were "America—Health Care," a panel presentation including Roger O. Egeberg, M.D., Assistant Secretary for Health and Scientific Affairs, Department of H.E.W.; Mr. Wilbur J. Cohen, former Secretary of H.E.W.; and Mr. Robert J. Myers, former Chief Actuary of the Social Security Administration. The second general interest program, "America—The Drug Scene," featured panelist Milton Helpner, M.D., Chief Medical Examiner for the City of New York; and Donald B. Louria, M.D., Chairman of the Department of Public Health and Preventive Medicine of the Medical-Dental College of New Jersey.

Meeting in conjunction with the Annual Session, the MAG House of Delegates considered a variety of reports and resolutions. The remainder of these Highlights will cover many of these matters. A detailed reporting of each proposal presented to the House, the subsequent recommendation of the Reference Committee to which it was referred and the final action taken by the House appears elsewhere in this issue of the *Journal*.

Abortion

A reference committee recommendation that MAG take no position on pending abortion legislation until after the Supreme Court decides on a Georgia case now before the Court was turned down by the House of Delegates. The original report of the State Legislative Committee recommended approval of five specific points incorporated in legislation presently pending in the General Assembly. The House voted separately on these five points with the following results:

APPROVED:

(1) Elimination of the Hospital Abortion Committee; (2) Authorized abortion to be performed in JCAH hospitals only; (3) Physicians should have the right to elect *not* to participate in an abortion for *any* reason.

NO POSITION:

Require a 10-day Georgia residency period immediately prior to obtaining an abortion.

REJECTED:

Statutory references to the 16th week of gestation as a limitation on abortion and adopted instead that MAG opposes any statutory provision limiting abortions by reference to length of gestation, but in the event the General Assembly insists on such limitation, that the period be specified as not less than 20 weeks.

In a separate action, the House approved a recommendation that MAG encourage additional Medicaid funds to be made available for childbirth, sterilization and therapeutic abortion, and that Medicaid policies in this regard be both liberalized and clarified.

National Legislation

The House reaffirmed its support of the AMA-sponsored "Medicredit" proposal. As explained in the report of the National Legislative Committee, the essence of "Medicredit" is to make federal financing available to individuals and families, at all levels of income, protection against the ordinary and catastrophic expenses of illness through a system of voluntary comprehensive health insurance.

The House of Delegates had taken a similar position last year, but realized that the "Medicredit" proposal had undergone some modifications.

MAG Dues

In considering the matter of MAG dues carried over from the 1970 House of Delegates, the reference committee noted the excesses of expenses over income.

both actual and potential, and accordingly recommended an increase from \$40 per year to \$100 per year, effective January 1, 1972.

The House voted affirmatively on this recommendation and in the process approved the 1971-72 MAG budget.

Georgia Medical Care Foundation, Inc.

In considering the recommendations on the MAG Medical Care Foundation, Inc., received both from the Foundation and the MAG Council, the House adopted the following two statements:

"... the Medical Association of Georgia establish as an operating policy that those who participate under the Medical Care Foundation concept in the field of Peer Review and also in the field of decision-making on the Board of Directors must be physicians in the active private practice of medicine and be earning the majority of their income therefrom. Consultation can be obtained from other non-practicing parties as is deemed necessary by our Utilization and Peer Review Consultants and by the Board. The final decision-making must rest in the hands of those who are actively practicing or we have indeed destroyed a basic concept of Peer Review. . . .

"That the House (of Delegates) assure the Board of Health of their total endorsement of this Foundation program, and assure the Board of adequate review mechanism for Medicaid claims.

"That membership of the Board of Directors of the Georgia Medical Care Foundation shall be comprised of physicians in full-time private practice of medicine, chosen on a statewide basis.

"That final authority in all claims reviewed reside by law in the State Board of Health."

Election of Treasurer

The House approved the concept of electing the MAG Treasurer (now appointed by Council) and instructed the Constitution and Bylaws Committee to prepare the necessary amendments so that they may be presented to the House in 1972 for formal adoption.

The concept to be embodied in these amendments will include provisions that the Treasurer will become a voting member of the Executive Committee and of Council, shall serve three-year terms of office, and shall be eligible to succeed himself for one term. The House turned down the recommendation that the Treasurer serve concurrently as Chairman of the Committee on Finance.

Constitution and Bylaws

The House adopted numerous amendments to the Bylaws designed to keep the basic document responsive to the wishes of the Association. It also adopted one technical Constitutional amendment and received one Constitutional amendment to lie on the table for a vote in 1972. Among the changes approved were as follows:

—Provided for the orderly succession to the Presidency in the event catastrophe incapacitates those previous in line. (Constitution amendment to be voted on in 1972.)

—Approved non-voting membership in the House of Delegates for one delegate from each of Georgia's two SAMA chapters.

—Provided for the counting of Life Members (non-dues paying) in the determination of the number of MAG Delegates from each component society.

—Authorized Executive Committee to accept or reject requests for MAG to assume original jurisdiction in professional conduct matters.

—Provided a membership reinstatement procedure that would require payment of all dues and additional dues in arrears during the year membership was lost as a condition of reinstatement.

—Provided that amendments to the Bylaws may be proposed by the House, Council, Executive Committee, the Committee on Constitution and Bylaws, or any group of five or more active members, provided they are received by the Constitution and Bylaws Committee not less than 75 days prior to the Annual Session, at which time they will be acted upon.

In other actions regarding the Constitution and Bylaws, the House rejected a proposed change to authorize membership for osteopaths. It also turned down a recommendation that each component society pay \$1.00 per year per active member to the MAG Foundation, to be used for an indigent member and widow fund. The House instead instructed Council to budget an equal amount from the general funds of the Association for this purpose.

Building Expansion

The House approved a Supplemental Report of the Council related to expansion of the MAG Headquarters Office Building. Council asked the House for authority to proceed with expansion based on a favorable feasibility study and the House voted affirmatively, with the understanding that Council would consider two potential approaches: (1) add two additional stories consisting of approximately 24,000 square feet, which includes removal of the front wing of the existing structure; or (2) add four additional stories of approximately 40,000 square feet.

Chiropractic

The House considered several items related to chiropractic, including the report of the Quackery Committee, which stated that “. . . the Committee (Quackery) concluded that the overriding quackery problem in Georgia was the growing menace of chiropractic. . . .” The House then adopted the following: (1) continuation of the Quackery Committee, adequately financed to perform its assigned job; (2) urge the appointment of local Quackery Committees to work with the MAG Quackery Committee; (3) County Medical Societies be encouraged to meet with their Representatives and Senators to discuss and expose chiropractic.

Special Ad Hoc Committees

In approving the report of the AMA Alternate Delegate (Dr. Dowda), the House gave its approval to the appointment of the following Ad Hoc Committees and charged these Committees to report to the March, 1972 meeting of Council: (1) liaison and involvement with specialty societies; (2) liaison and involvement with medical students; and (3) committee to study the MAG committee structure.

Regional Medical Program

The House approved the report of the GRMP Coordinator which included a request for MAG assistance in having \$34.5 million restored to the national Regional Medical Program budget for fiscal 1972. The House approved a resolution for transmittal to the AMA House of Delegates to accomplish this objective.

New Established Health Care Corporations

The House registered strong opposition to closed panel group practice corporations being established by the Department of H.E.W. when such corporations are created without the joint planning and approval of MAG and its component County Medical Societies.

In adopting the report of the reference committee, the House recognized that we are in an era when careful consideration must be given to new systems of health care delivery. It objected, however, to unilateral action and specifically called on the Office of Comprehensive Health Planning to rescind its application for this type of health care corporation in Columbus, Ga.

Unsolicited Drugs

The House adopted a resolution which requested the pharmaceutical companies to cease mailing unsolicited drug samples to Georgia physicians.

Awards Presented

T. A. Sappington, M.D., Thomaston, was recognized as the General Practitioner of the Year; John Kirk Train, M.D., Savannah, was presented with the Distinguished Service Award; A. J. Kravtin, M.D., Columbus, received the Civic Endeavor Award and Curtis G. Hames, M.D., Claxton, was presented with the Hardman Certificate.

Awards for Scientific Exhibits were presented as follows: First Place was awarded to Arnolde Fiedotin, M.D., Atlanta, for "Coronary Cinearteriography in the Diagnosis of Arteriosclerotic Heart Disease"; Second Place was taken by John T. Godwin, M.D., Atlanta, for "Rapid Diagnosis by Cytological Techniques"; and Third Place was awarded to Gerald T. Zwiren, M.D. and H. Gibbs Andrews, M.D., both of Atlanta, for "The Management of Neonatal Intestinal Atresia."

Four GaMPAC awards were presented—two for the highest percentage of GaMPAC membership, which went to Altamaha County and the Fourth District; a third for the largest financial contribution to GaMPAC which went to the physicians and their wives in DeKalb County; and a special recognition award to Preston D. Ellington, M.D., Augusta, retiring member of the GaMPAC Executive Committee.

Officers

The following MAG officers were elected and/or installed for the 1971-1972 Association year: W. C. Mitchell, M.D., Smyrna, President; F. William Dowda, M.D., Atlanta, President-Elect; F. G. Eldridge, M.D., Valdosta, Immediate Past President; Henry D. Scoggins, M.D., Augusta, First Vice President; Braswell E. Collins, M.D., Macon, Second Vice President; Harrison L. Rogers, Jr., M.D., Atlanta, Speaker; Preston D. Ellington, M.D., Augusta, Vice Speaker; J. W. Chambers, M.D., LaGrange, and John S. Atwater, M.D., Atlanta, AMA Delegates; F. G. Eldridge, M.D., Valdosta, and Henry S. Jennings, M.D., Gainesville, AMA Alternate Delegates.

Future Annual Session Meeting Sites

It was announced that future sites of MAG Annual Sessions would be as follows: 1972, Macon; 1973, Augusta; 1974, Savannah; 1975, Atlanta; 1976, Jekyll Island, and 1977, Macon.

CANCER OF THE COLON AND RECTUM WORKSHOP

Wednesday, August 4, 1971

**Sewell Auditorium, Georgia Baptist Hospital
300 Boulevard, N.E.—Atlanta, Georgia**

Sponsored by: Georgia Baptist Hospital

**Co-Sponsored by: Georgia Regional Medical Program and American Cancer
Society, Georgia Division, Inc.**



PRESIDENT'S LETTER

Y'ALL COME

THE 117TH ANNUAL SESSION of the MAG which was held at the Marriott Motor Hotel in Atlanta has just concluded. It was an excellent meeting. The program and general format, thanks to Preston Ellington and his fine committee on arrangements, was outstanding. Fulton County, along with the other Metropolitan County Medical Societies, acting as hosts for the occasion, came up with a real dish of Southern Hospitality, and I must say that a good time was had by all.

I must slow down here and say that a good time was had by all that *attended*. The total membership registered was 648, which was an increase of 12 over the number registered at Jekyll last year. The Woman's Auxiliary, Exhibitors, and guests gave us a grand total of 1,348 registered this year, which was an increase of 187 over last year. Percentage-wise, 648 out of a total membership of almost 4,000 amounts to less than 18 per cent of our members who took advantage of this meeting, and the other 80 per cent plus, were the losers.

It is my feeling that more of our membership should be taking a greater part in the activities, because it is *your* Association, and YOU (all the members) should help run it. Your suggestions and help will be welcomed at any time, at any of the Executive, Council, or Annual Session meetings.

With this in mind, I feel sure that if more of you visited these meetings, you would realize what a tremendous job your Association is doing for you. But again, we need your help. I think instead of anyone asking what the MAG does for me, they should, in the words of John F. Kennedy, ask, "What can I do for my Association?"

Now that I've gotten that off my chest, I'll get back to the Annual Session Meeting. Since it was held practically in my front yard, I took advantage of the occasion to ask my family (grandchildren included) down and introduce them to those present at the banquet on Saturday night. As I said in their introduction, I wanted everyone to see what keeps me young and going and, of necessity, on the ball.

I'm looking forward to a challenging year, but a good one, for I know I can depend on all the committees for a repeat performance, and with the help of our excellent Headquarters' Staff, as well as the Executive Committee and the Council, I'm sure the upcoming year will be a success.

Let me say again, "Y'all Come"!

W. C. Mitchell

W. C. Mitchell, M.D.
President, Medical Association of Georgia



AFTER SURGERY—REACH TO RECOVERY

EARNEST C. ATKINS, M.D., *Atlanta*

CANCER OF THE BREAST is a leading cause of death from cancer in women. We have 1,200 new cases in Georgia and 550 deaths in Georgia annually from this form of cancer.

We all give our patients the best scientific care available, but this is not enough. The woman who loses a breast needs supportive care.

After a radical mastectomy 18 years ago, Mrs. Terese Lasser founded Reach to Recovery on this principle. She set out to give these patients a sense of belonging. She organized a group of volunteers, and now this program is operating under the American Cancer Society with Mrs. Lasser serving as consultant. All volunteers have undergone a mastectomy themselves and are five-year postoperative. These volunteers enable the surgeon to provide mastectomy patients with specialized assistance without interfering with the doctor-patient relationship. A doctor must certify that each volunteer is physically and emotionally equipped to participate in the program.

After mastectomy, the patient usually feels alone and many undergo depression when they wake up from the anesthesia and find their breast missing. The Reach to Recovery visit can be timed during the depth of your patient's depression—you can't imagine the good effect of a pretty, neat, well-trained volunteer who is living a normal life coming into a patient's room saying, "We're in the same boat!" The psychological stimulation is tremendous because we all want to belong, and this is living proof of a fine group of women to which your patient now belongs.

Upon visiting a patient, the volunteer provides a Reach to Recovery kit. This kit contains a Reach to Recovery manual (information for the patient and her family), a ball and rope for exercise and a temporary prosthesis for the patient to wear home from the hospital. This not only gives the patient a sense of well-being but also a sense of balance. The volunteer gives information on exercise, suggestions for bra comfort and clothing adjustments and explanations of the various prostheses. If you want the straight poop, ask the lady who wears one. She also answers questions the patient may have of a personal nature—and even talk with her husband or family. Often you and I can't answer these questions because we haven't been there. The volunteer does not take your place and never makes comparisons or answers medical questions; however, they do recommend that the patient discuss these matters with their own physicians.

Medicine is a team effort—if we physicians do not avail ourselves of the Reach to Recovery Program, we are leaving off a valuable team mate. After surgery call your local American Cancer Society unit and the volunteer will be a living inspiration to the patient.

After surgery—Reach to Recovery.

2910 N. Druid Hills Road

THE ASSOCIATION



NEW MEMBERS

Ballagas, Antonio R. Active—Baldwin—Anes	Central State Hospital Milledgeville, Georgia 31061
Catanzaro, Marshall J. Active—Fulton—R	3312 Piedmont Rd., N.E. Atlanta, Georgia 30305
Clair, Alvin H. Active—Fulton—D	2739 Felton Dr. East Point, Georgia 30344
Clizer, Edwin E. Active—Fulton—Path	265 Ivy St., N.E. Atlanta, Georgia 30303
Gamwell, John W. Active—Fulton—Or	35 Linden Ave., N.E. Atlanta, Georgia 30308
Gonzalez, Pablo E. Active—Fulton—Anes	20 Linden Ave., N.E. Atlanta, Georgia 30308
Grady, Donald F. Active—Fulton—NS	1293 Peachtree St., N.E. Atlanta, Georgia 30309
Grant, R. Perry Active—DeKalb—P	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Insignares, Manuel S. Active—Fulton—Anes	20 Linden Ave., N.E. Atlanta, Georgia 30308
Mallory, James D., Jr. Active—Fulton—P	3355 Lenox Rd., N.E. Atlanta, Ga. 30326
Mason, James L. Active—DeKalb—P	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Mercer, Lloyd F. M. Active—Whitfield—GP	P.O. Box 1168 Dalton, Georgia 30720
Moyer, Leroy N. DE-2—Fulton—OBG	80 Butler St., S.E. Atlanta, Georgia 30303
Pine, Robert H. Active—Dougherty—P	1200 Valley Rd. Albany, Georgia 31705
Read, Silas C., Jr. Active—C. W. Long— Oph	759 Cobb St. Athens, Georgia 30601
Reynolds, Robert E. Active—Richmond—I	Medical College of Georgia Augusta, Georgia 30902
Rogers, Edward A., Jr. Active—Colquitt—OBG	717 Colonial Village Moultrie, Georgia 31768
Rowland, David M. DE-2—DeKalb—U	80 Butler St., S.E. Atlanta, Georgia 30303
Sanders, James L. Associate—Richmond —OBG	Talmadge Memorial Hospital Augusta, Georgia 30902
Sheahan, Robert C. Active—Fulton—Adm	1800 Peachtree St., N.W. Atlanta, Georgia 30309
Sones, Peter J. Active—Fulton—R	1365 Clifton Rd., N.E. Atlanta, Georgia 30322

Soriano, Maria J. R. Active—Fulton—P	2045 Peachtree Rd., N.E. Atlanta, Georgia 30309
Stephenson, John A. Active—Fulton—Pd	1938 Peachtree Rd., N.W. Atlanta, Georgia 30309
Tropauer, Alan Active—Fulton—P	2045 Peachtree Rd., N.E. Atlanta, Georgia 30309
York, Paul S. Active—C. W. Long—U	1010 Prince Ave. Athens, Georgia 30601

SOCIETIES

Alexander Heard, Ph.D., chancellor of Vanderbilt University, was the featured speaker at the April meeting of the **Georgia Medical Society**.

Richmond County Medical Society, in cooperation with the Medical College of Georgia and the University Hospital, sponsored a Nuclear Medicine Symposium at the hospital in April.

PERSONALS

First District

Curtis Hames and the Evans County Heart Research Clinic have received a grant from the National Institute of Health to conduct a research project in a new area of heart disease. The new study will provide data for the association of "triglycerides and heart disease incidence."

Fifth District

W. L. Ryder was elected to the board of AMI, Inc., in Atlanta in May.

Carter Smith, Sr., was re-elected to the Board of Regents of the American College of Physicians at that organization's annual meeting in Denver in April.

Seventh District

Douglas D. Glover was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting in San Francisco in May.

Eighth District

Hartwell Boyd has been re-elected as a trustee, state-at-large, of the Georgia Hospital Association.

Tenth District

Stephen Hall King will become the Director of the 11-county Northeast Georgia Health District in July, replacing Gerald B. Creagh, who is retiring.

R. E. Shiflet has been elected chief of surgery at St. Mary's Hospital, Athens, for 1971 and 1972. He also was elected president of the entire staff at Athens General Hospital for 1971.

DEATHS

James Croswell Brim, Sr.

James Croswell Brim, Sr., died April 22 at his home in Pelham. He was 69.

Born in Sasser, Georgia, in 1902, he was graduated from Mercer University and the Medical College of Georgia. He then opened practice in Pelham, where he remained for the next 40 years.

Dr. Brim served the Pelham Banking Company as a member of the Board of Directors, President, and Vice Chairman of the Board of Directors. He was a member of the Hand Memorial United Methodist Church, serving as Trustee, member of the Administrative Board, delegate to the Annual Conference and member of the pastor's Parrish Committee.

He was a charter member of the medical staff at the Mitchell County Hospital in Camilla and was past Chief of Staff there. Dr. Brim also served as Chairman of the Mitchell County Board of Health for 30 years, was a member of the Mitchell County Medical Society, past president of the Second District Medical Society, member of the Georgia Academy of General Practice, American Medical Association, Medical Association of Georgia, and Southern Medical Association. He was a charter member of the Pelham Rotary Club.

Dr. Brim is survived by his widow, the former Elizabeth Wells; a son, James C. Brim, Jr., Pelham; a daughter, Mrs. Wright Turner, III, of Tifton; a sister, Mrs. Lucy Edwards of Albany, six grandchildren and several nieces and nephews.

Rhea W. Richardson

Rhea W. Richardson died in a Macon Hospital on April 9 after a brief illness.

Born in Baltimore, Md., Dr. Richardson was a graduate of City College in Baltimore and the University of Maryland Medical School.

He was superintendent of Macon Hospital for three years, resigning July 8, 1931, to do graduate work at Tulane University Medical School.

He had practiced medicine in Macon for more than 40 years, specializing in eye, ear, nose and throat.

Dr. Richardson was a member of All Saints Episcopal Church, Macon Masonic Lodge No. 5, Al Sihah Shrine Temple, American Medical Association, Bibb County Medical Society and the Association of Surgeons of the Southern Railroad.

He is survived by his widow, the former Frances Campbell; three sons, Edwin Richardson of Ft. Valley, Joe B. Richardson, M.D., Lakeland, Fla., and Ridgely Richardson of Macon; a step-daughter, Mrs. Roger Landolt of Wilmington, Del.; a stepson, Jack Hughes, Atlanta and 14 grandchildren.

W. C. Waters, Jr.

W. C. Waters, Jr., died May 4 in a private Atlanta hospital at the age of 71.

Retired chief of staff at St. Joseph's Infirmary, Dr. Waters was born in McKenzie, Tenn., and was a graduate of Emory University School of Medicine.

He was a member of Druid Hills Methodist Church, the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association and the Askaplois medical honor society. He was a diplomate of the American Board of Internal Medicine.

Dr. Waters is survived by his widow, two sons, a sister and a brother.

DEAN'S

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Adventure in Sport ■

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favorite sport. Come let us provide you
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POSITIONS AVAILABLE for Chief of Surgery, Chief of OB-GYN, Chief of Pediatrics in progressive 600-bed community Hospital associated with Med. College of Ga. Need vigorous young men under full time Med. Dir. and Dir. of Med. Ed. to coordinate teaching activities. Please send Curriculum Vitae to Med. Dir., The Macon Hospital, 777 Hemlock St., Macon, Ga. 31201.

EMERGENCY SERVICE PHYSICIAN—450 bed general hospital, Southwest Georgia. Active emergency room service. Contract with \$35,000.00 guarantee. Must have Georgia license. Contact Administrator, Phoebe Putney Memorial Hospital, Albany, Ga. 31702. (912) 436-5741.

INTERNSHIP AND RESIDENCY PROGRAMS available in a 600-bed community Hospital associated with Med. College of Ga. Under full time Dir. of Med. Ed. Stipend. ECFMG Certification required. Write: Dir. of Med. Ed., The Macon Hospital, 777 Hemlock St., Macon, Ga. 31201.

OFFICE SPACE available for well trained M.D. Ideal for Pediatrician, G.P., or Surgeon. Air-conditioned Medical Arts Building centrally located in Marietta, Ga. 5 min. to Kennestone Hospital. Full participating partnership in x-ray, bio-chemical laboratory available. No investment required. (404) 428-0113.

Moultrie, located in southwest Georgia, is very anxious to secure medical doctors in the following specialties:

INTERNAL MEDICINE
UROLOGY
PEDIATRICS

The Medical Staff of the Vereen Memorial Hospital, the Colquitt County Medical Society and the Colquitt County Hospital Authority unanimously join together in asking anyone interested to please call or write the Administrator of the Vereen Memorial Hospital so arrangements can be made for you to come look us over. Call area code 912-985-3420, Moultrie, or write the Administrator.

JOURNAL
OF THE MEDICAL
ASSOCIATION

JULY/1971

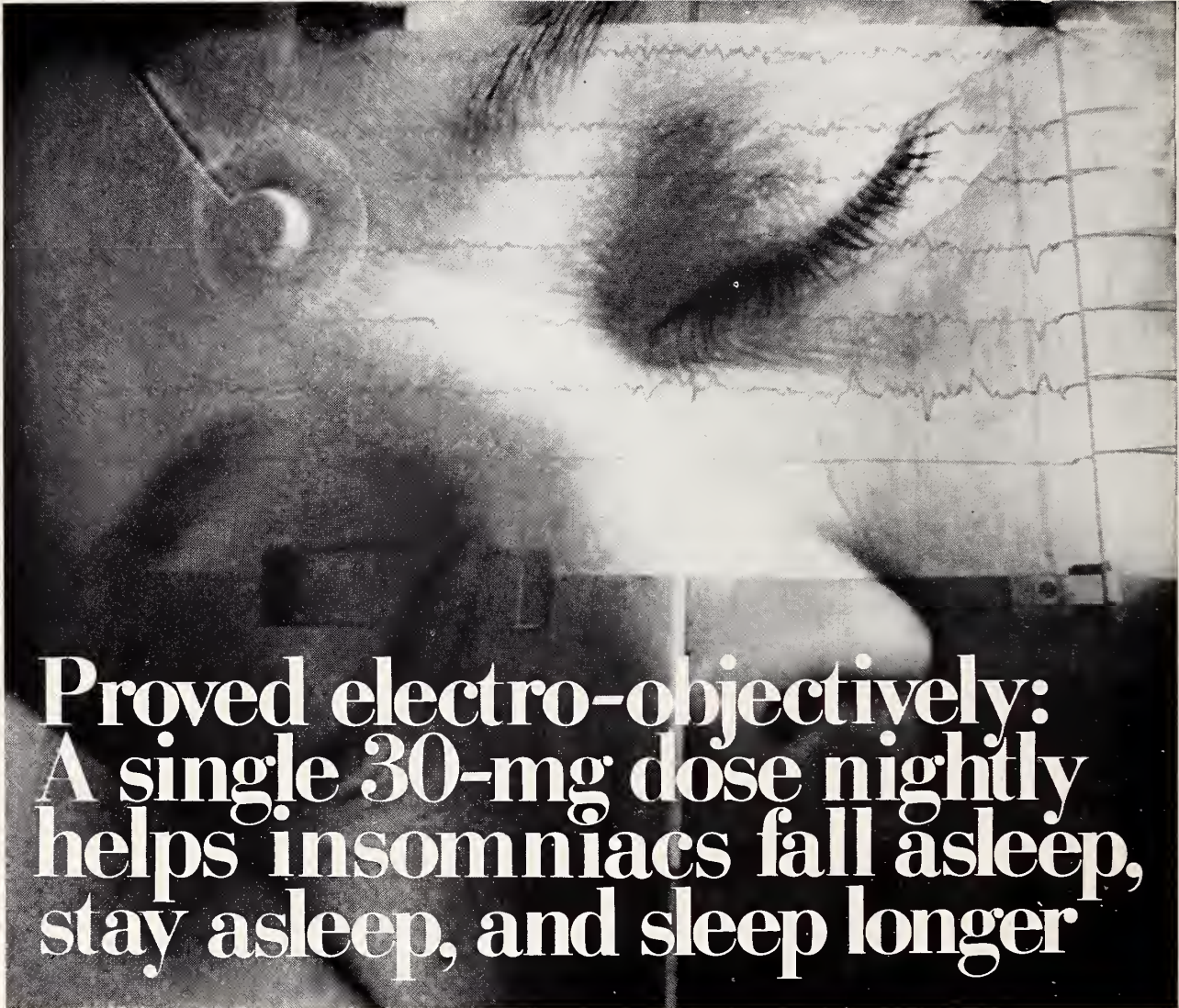
Georgía

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Tuberculosis
in Georgia
See Page 257



Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,¹ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration.

Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

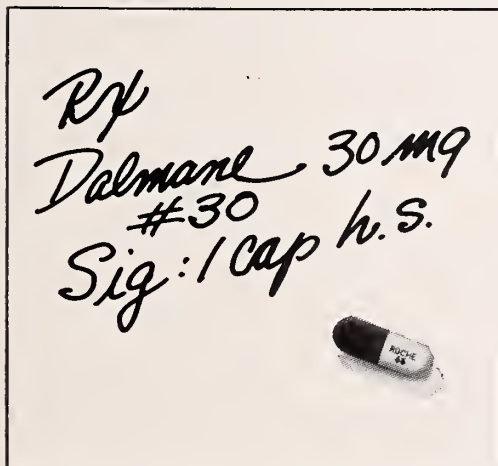
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane**[®]
(flurazepam hydrochloride)

Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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Mycobacterium tuberculosis. Photograph courtesy of Joe Jackson, Department of Med- ical Illustration, Emory University, Atlanta. Layout by Robert Hamill, Atlanta.

The Medical Method Versus the Judicial Method of Hospitalization of the Mentally Ill

A Progress Report

ADDISON M. DUVAL, M.D.,* *Atlanta*

SHOULD THE DECISION for hospitalization of a mentally ill person be made by a physician or a judge? Basically, that is the question which Georgia's counties have had to decide on under the provisions of the revised Health Code (Chapter 88-5) which went into effect at the beginning of 1970.

During calendar year 1970, Georgia tried out a revision of the State Health Code, Chapter 88-5, which permitted each county (1) to adopt a new medical hospitalization procedure for its mentally ill, or (2) to continue the old judicial procedure whereby every individual being admitted involuntarily for treatment is required (whether they wish it or not) to be examined by a three-man commission on order of the Court of Ordinary. This commission's recommendations for legal commitment, if unanimous, made the subsequent commitment by the Ordinary mandatory. If the decision was less than unanimous, the Ordinary was required to dismiss the action and release the patient.

Various objections to the new medical hospitalization plan were voiced before, during and after the passage of this legislation. Some of these objections were as follows:

1. Increased expense on counties.
2. Gives a physician too much authority.
3. Gives the Health Department too much power.
4. Prevented a patient having his "day in court."
5. Possible unconstitutionality.

For patients being admitted through the medical route, the law required the establishment of three kinds of examining and treatment facilities. These were (1) Emergency Receiving, (2) Evaluation, and (3) Treatment. These arrangements were to be

provided at the community level, if possible, and if not, then these three services would be provided in each of the Regional State Hospitals and at Central State Hospital.

Sixty counties chose to follow the medical hospitalization procedure during the year. In order that we might find out how the new procedure has worked during the year, we submitted a brief questionnaire to the Chairman of the Board of County Commissioners of each of these counties. A list of the questions and answers from the counties which replied to our request is outlined below.

Of the 60 counties using the medical procedure at the time of the questionnaire, 43 have responded. Five additional counties have adopted the medical procedure since that time.

Summary: Reports from the counties indicate overwhelming approval of the medical procedure by counties using it during the past year. This should encourage other counties to adopt this more practical and humane method.

From these replies, it can be concluded that most or all of the early criticisms of the new law turned out to be invalid. By and large the counties like the new medical admission plan. Only one indicated it might revert to the old judicial method if an improving amendment was not adopted. This amendment—to permit the Ordinary to order an emergency examination of a person if two citizens made affidavit that in their judgment the patient was mentally ill and dangerous to himself or others—has already been presented to the General Assembly and has our support.* This was found necessary where a private physician was not available to ex-

* Director, Division of Mental Health, Georgia Department of Public Health.

* Amendment passed by Legislature effective July 1, 1971.

HOSPITALIZATION / Duval

QUESTION 1. Do you like this method better than the former judicial commitment?

Replies: 35—like better than judicial
5—about the same
3—qualified no

—
43

QUESTION 2. Any major difficulty?

Replies: 33—no
9—yes
1—no reply

—
43

1. Hard to explain to family.
2. Hard to get dangerous patients to physician.
3. Confusion re guardian ad litem.
4. No reason given.
5. Too many forms.
6. Too much delay at Central State Hospital. (2)
7. Patient held in jail too long.
8. Confusion re responsibility.

QUESTION 3. Plan to continue the method?

Replies: 42—yes
1—questionable

—
43

QUESTION 4. Any amendments suggested?

Replies: 31—no
8—yes
4—no reply

—
43

1. Give Ordinary authority for emergency admission. (4)
2. Improve guardian ad litem.
3. Simplify the law.
4. Extend 5-day evaluation period.
5. Authorize hospitalization of alcoholics.

QUESTION 5. Would you like to receive a summary of this report?

Replies: 35—yes
6—no
2—no reply

—
43

amine such patient. Other amendments may be found to be advisable as time goes on.

Even though five additional counties have recently changed from judicial to medical, we would like to see the number increase more rapidly.

The Mental Health Committee of the Medical Association of Georgia suggested that this progress report be provided to association members in an effort to have more physicians who are members of the staffs of County Hospitals urge their hospitals to decide to qualify at least as Emergency Receiving facilities which most could easily do, and in this

way to convince their counties to adopt the more humane medical hospitalization method.

The professional staff of the Division of Mental Health stands ready at all times to meet with the staffs of County Hospitals or with other county officials in an effort to provide complete information on this important subject.

Every physician should be interested in providing better, simpler and more humane hospitalization admission procedures for the state's seriously mentally ill. Can we count on you to help?

47 Trinity Avenue., S.W.

Medical Grand Rounds—Thyroid Nodule

DICKSON B. DUNLAP, M.D.,* *Augusta*

BECAUSE OF ITS LOCATION, the thyroid has the dubious distinction of being the only endocrine gland that the patient and his friends can readily see and feel. This and the tendency for goiter to occur in some 4 per cent of our population insures that large numbers of patients each year present with abnormalities requiring evaluation.²⁵ For these reasons the clinical setting harboring the question of thyroid malignancy is by no means a rarity in the physician's office.

If an uncomplicated diffuse or nodular goiter is present, the disposition is relatively easy. Such assurance has not been achieved without a good deal of difficulty. In fact, it has only been in the last decade that some semblance of clarity has been conferred upon what was often a frightfully confusing situation.

In the late 1940's, Cope and others, and Cole, et al., reported that the incidence of cancer was 10 per cent in surgically removed non-toxic nodular goiters.^{5, 6} Other authors, namely Pemberton,¹⁸ Brenzier and McKnight,⁴ Ward,²⁸ and Crile⁷ noted a somewhat lesser incidence, i.e., 2.7 to 5.6 per cent. But this was small comfort to the physician seeing large numbers of patients with goiters.

Evidence to the contrary came from several sources. Jaffé, who found nodular goiter in 24 per cent of 950 autopsies at the Cook County Hospital in Chicago,¹³ was able to make the anatomical diagnosis of thyroid carcinoma only twice in this series. Obviously the incidence of carcinomas in this group of goiters was far below that which would have been predicted from the surgical series described above. Similarly, Vanderlaan's series from the Boston City Hospital turned up only five thyroid carcinomas among 18,688 post mortem examinations.²⁷ Reviews at the Peter Bent Brigham and Massachusetts General Hospitals yielded an approximate incidence of 1:1000.

Diminishing Incidence

Another hint of the true state of affairs was a by-product of the massive programs of iodine prophylaxis which began in the 1920's. During the next several decades the incidence of goiters in certain populations diminished from greater than 30 per cent to less than 10 per cent. With this decrease in total number of cases at risk, there was no appreciable change in the 0.5/100,000 death rate from thyroid carcinoma published between 1939 and 1949.³⁰ Had there been a direct relationship between goiter and cancer, a lessening of thyroid carcinoma deaths would have been expected.

Sokal has pointed out that the cumulative incidence of thyroid carcinoma over an average lifetime is 1500 per million population and that the cumulative incidence of non-toxic nodular goiter is approximately 100,000 per million.²⁴ He concluded that since not all thyroid cancers arise in goiter, the lifetime risk must be less than one per cent. On the basis of his surgical experience, Sloan has suggested that no more than 30 per cent of thyroid carcinoma arises in pre-existing goiters.²³ If this figure is applied to Sokal's estimate of incidence, there is a 0.45 per cent lifetime expectancy of thyroid cancer for a patient with a non-toxic nodular goiter.

How can the conflict between the 2-10 per cent found in surgical series and the expected lifetime incidence of 0.45 per cent be resolved? Perhaps the difference is more apparent than real. The total number of cancers in Cope's series found in the course of 170 thyroidectomies for nodular goiter was 17. While it may be true that the incidence of cancer in these 170 nodular goiters was 10 per cent, one cannot conclude from this data that the incidence of cancer in all other nodular goiters is the same. These patients were referred because there was something about their goiter that bothered their physician; frequently, it was the fear of cancer. It should not be surprising, then, that neoplasia was much more prevalent in this selected group.

* These conferences are taped weekly and are selected and edited by Dr. Joseph P. Bailey, Jr., Professor of Medicine, Medical College of Georgia. The participants are principally faculty and house staff of the Department of Medicine, or Junior Medical Students assigned to the patients. Members of other departments are so identified.

Different Approach

A different and much more meaningful approach was accomplished by the study of 5,127 persons in Framingham, Mass.²⁶ Two hundred and eighteen patients, many with single nodules and others with multinodular goiters, were discovered on the routine examination of a randomly selected population. Throughout the course of the 15-year follow-up, 45 thyroidectomies were undertaken because of the fear of cancer. Up until the time of the last report not one carcinoma had been found. Incidentally, 68 new goiters and nodules appeared during the routine biennial examination of the entire study group; at the conclusion of the project none of these had undergone changes suggestive of cancer. Dealing with an unselected rather than a referral group creates a very different concept of the incidence of cancer in goiter, one that seems to fit best with general clinical experience. Despite the body of literature which attests to the high incidence of carcinoma in goiter, it would seem appropriate to conclude that the presence of a non-toxic nodular goiter itself is no indication that the patient has or necessarily will develop thyroid carcinoma.

A single nodule is by far a more difficult lesion to contend with, especially if it occurs in an otherwise normal gland. There is little doubt that many normal people have such lesions. In a careful autopsy study from the Mayo Clinic, one-half of patients with clinically normal thyroids had multiple or single nodules.¹⁶ The incidence correlated remarkably well with age, being greater than 50 per cent in patients past the 6th decade.

This reassuring information must be tempered by the realization that thyroid carcinoma generally arises in the setting of a normal gland and may well present early in its clinical course as a nodule. It is this knowledge of the natural history of thyroid neoplasia that creates concern as to the appropriate maneuver to undertake when confronted by a solitary thyroid nodule.

Opinions are divided. Astwood has reported on 37 such patients who were simply given three grains of desiccated thyroid daily and followed for further development.² Not one of the nodules enlarged or underwent changes suggestive of cancer, and of course none of the patients had to undergo excisional biopsy. But the clinician who would treat all such nodules with suppressive therapy must assume the risk of overlooking an occasional malignancy. Whether or not this is deleterious to the patient with thyroid carcinoma has been questioned.¹ At our present state of knowledge, it would seem justifiable to characterize the lesion further if possible.

Fortunately, the thyroid scan lends itself admirably to this pursuit. Nodules on the basis of their uptake of I¹³¹ can be classified into three broad categories. Those showing uptake of the administered tracer dose of I¹³¹ that is similar to the rest of the thyroid are called *functional*. Infrequently the nodule is the only area of function; the lesion is then spoken of as being *autonomous*, the rest of the gland *suppressed*. For practical purposes, "hot" or *autonomous* nodules are never cancer. Any nodule that does not function as well as the surrounding thyroid or does not function at all is called a *cold* nodule. The incidence of cancer in this lesion approaches 10 per cent²¹ and unless there is a clear contraindication, surgery is indicated.

There are other features of lesions of the thyroid that bear mentioning. The presence of vocal cord paralysis or of local adenopathy unrelated to another disease are both good reasons to seek tissue diagnosis. The absence of adenopathy does not exclude neoplasia as follicular carcinoma is characteristically unaccompanied by local lymphatic enlargement. Cancer is frequently hard. At times, however, it is not. Old areas of inflammation accompanying thyroiditis, infarct, and many adenomas may be firm as well. Nonetheless, a stony hard nodule is generally considered to be indication enough for surgery. Adherence to surrounding structures is a late finding, and by no means is it limited to carcinoma; non-toxic nodular goiters and thyroiditis are common offenders. The younger the patient is, the more likely that a suspicious lesion is cancer. In children a single nodule should always be removed. Likewise, it is recommended that nodules occurring in patients with a history of x-ray therapy to the head and neck region in childhood should also be excised.^{10, 19, 22} For reasons that currently are obscure, men have a lower incidence of minor thyroid abnormalities than do females. A given lesion in a male, therefore, is more likely to be cancer than is a similar lesion in a female.

Medullary carcinoma of the thyroid has only recently been recognized.¹² Whereas, papillary carcinoma frequently is accompanied by involved cervical nodes, and follicular carcinoma has often metastasized to distant sites with little in the way of local disease, the medullary carcinoma is capable of both.¹¹ Generally considered to take origin in the parafollicular or calcitonin secreting cell, this variety of carcinoma exhibits a fascinating yet little understood interrelationship with other endocrine syndromes.^{8, 15, 17} Thus, it may be noted in conjunction with a pheochromocytoma in a sporadic fashion or both of these lesions may appear together in the same family.^{3, 29} Finally, several patients and fam-

ilias with parathyroid adenomas, medullary carcinomas and pheochromocytoma have been reported.^{9, 14, 20} In light of this information, a family or personal history of pheochromocytoma, medullary carcinoma or any variety of the multiple endocrine adenomata syndrome makes careful examination and follow-up of the thyroid a necessity.

Frequently there will be patients in whom the indications are not sufficient to warrant excisional biopsy but in whom the problem leaves sufficient doubt to serve as a cause for concern. Careful follow-up with suppressive therapy is an excellent interim measure. Our policy in this regard is to give increasing doses until evidence of mild intoxication appears. At this point the dose is decreased slightly. An alternate method is to continue to increase the dose until the I¹³¹ uptake approximates the lower limit of normal. If the lesion shrinks after several months, all well and good. Simply continue the patient indefinitely on the established dose. If it continues to enlarge despite adequate treatment, surgical removal is best. If the lesion in question doesn't change appreciably, careful follow-up with suppressive therapy may be continued or surgical excision may be elected.

Medical College of Georgia

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COMMITTEE CONCLAVE

The Fourth Annual Conclave of MAG Committees will be held on Saturday and Sunday, August 7-8, 1971, at the Sheraton-Biltmore Hotel, Atlanta. Since its inception in 1968, the concept of the Conclave of Committees has served to strengthen and improve the operational effectiveness of the Medical Association of Georgia. Twenty-four of the 32 MAG operating committees will meet in the same location on the same weekend, thereby creating intra-committee relationships which will make possible direct dialogue between committee members, chairmen, and the officers of the Association. MAG members are invited to attend any committee holding special interest for them so that the committee will have the benefit of their counsel.

This rather infrequent endocrinopathy seems to be amenable to therapy in most cases.

Amenorrhea and Infertility After Oral Contraception

STEPHEN R. GOLDMAN, M.D. and EDWIN DALE, PH.D., Atlanta

AN ESTIMATED 8.5 million women in the United States utilize some type of oral contraceptive agents as their chosen method of birth control.¹² While the contraceptive efficacy of these compounds is without question, there are a significant number of reports of side effects associated with synthetic estrogen-progestin prophylactic therapy appearing with frequency both in popular press and medical literature.^{1, 6, 14, 18, 19} The conjectural association of chemical contraceptives and life threatening diseases, e.g., thromboembolism, has received the greatest publicity and lesser effects have been given only minor notice. Practicing gynecologists, however, are reporting increasing numbers of case histories of patients presenting with the chief complaint of secondary amenorrhea and involuntary infertility subsequent to oral contraceptive therapy. This lesser known adverse effect is of serious consequence to the young woman who has utilized chemical contraception and, following discontinuance, desires to become pregnant. Her medical evaluation may require a prolonged and extensive endocrine work-up. In this paper we review 82 reported cases of secondary amenorrhea and infertility which have appeared in the recent medical literature^{3, 7, 8, 11, 13, 15, 17, 20} with the intent of presenting to the practicing physician information as to etiology, diagnostic evaluation and management of this important clinical syndrome.

Summary of Data

The series of cases reviewed by authors and date of publication are shown in Table I. The data from these cases are summarized as follows:

AGE—Of the 82 patients reviewed, the youngest

TABLE I SUMMARY DATA OF 82 REPORTED CASES REVIEWED IN THIS COMMUNICATION			
Author	No. of Cases	Year of Publication	Reference
1. Whitelaw, et al.	17	1966	20
2. Dodek & Kotz	4	1967	3
3. Horowitz	6	1968	8
4. Shearman	22	1968	15
5. Spellacy	4	1968	17
6. Rankin	2	1969	13
7. Homesley & Goss	13	1970	7
8. MacLeod, et al.	14	1970	11

was 18 and the oldest 36. Mean age of all patients was 25.3 years. This is comparable with the age distribution of most women taking oral contraceptives, and therefore, is not considered significant.

PRIOR MENSTRUAL HISTORY—Eighteen (22 per cent) of the 82 patients had histories of irregular menses prior to onset of oral contraception. The remaining 64 patients had normal catamenia. The series collected by Horowitz et al.,⁸ however, comprised, by design, only patients with previously regular menses, thus excluding an untold number of patients with prior menstrual irregularities. Correction by exclusion of this series gives a total of 25.0 per cent with history of menstrual dysfunction.

GRAVIDITY—Of the 82 patients studied, the gravidity of 79 was known. Fifty-four of the 79 were nullgravidas at time of presentation. The overall distribution with respect to gravidity is shown in Table II.

DURATION OF TREATMENT—Distribution of the group with respect to this parameter is shown in Table III. The patients reviewed utilized oral contraceptives for an average duration of 18.9 months.

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Acknowledgment: This study is supported, in part, by a grant from the General Research Support Fund of Emory University. We wish to thank M. G. Freeman, M.D., W. E. Josey, M.D., and W. N. Long, Jr., M.D., for their critical reading of the manuscript.

TABLE II
DISTRIBUTION OF PATIENTS' STUDIES WITH
RESPECT TO GRAVIDITY

Previous Pregnancies	Number of Patients
0	54
1	11
2	4
3	7
4	3
Questionable	3

TABLE III
DURATION OF USE OF ORAL CONTRACEPTIVES

Months	Number of Patients
< 6	17
7-12	15
13-24	28
25-36	13
37-48	6
> 48	3

DURATION OF AMENORRHEA—In 64 of the 82 cases presented, the specific complaint of the post-treatment period was amenorrhea (Table IV). Of the remaining patients, 8 presented with "irregular cycles," 4 with significantly increased intervals between cycles, 2 with anovulatory irregular bleeding cycles, 2 with infertility only, and 2 with dysfunctional uterine bleeding.

At the respective times of publication, 19 patients in the various series were experiencing continued amenorrhea or a dysfunctional pattern. The duration of amenorrhea in selected ones of these patients ranged from 12 months (in 5 patients), 20, 22, 27, through 60 months. The remainder of patients had either undergone return to normal menses, or data was unavailable at time of publication. The average duration of amenorrhea in this group was 12.4 months with 4 cases of less than 6 months duration.

TABLE IV
DISTRIBUTION OF PATIENTS ACCORDING
TO PRESENTING COMPLAINT

	Number of Patients
Amenorrhea (> 6 mos. duration)	64
"Irregular cycles"	8
Increased interval	4
Involuntary infertility	2
Dysfunctional bleeding	2
Anovulatory/Irregular bleeding	2

COMPOSITION OF ORAL CONTRACEPTIVE AGENTS INVOLVED IN CASES REPORTED—

A total of 22 different regimens was used by the 82 patients. In only two cases was a sequential agent involved, and one of these patients also had been on a combination regimen. In seven cases the product involved was designated merely as a "combination product." For a description of the chemical composition of oral contraceptives currently available, any recent gynecologic endocrinology text may be consulted. Table V shows the incidence of complication with respect to dosage of progestin only. Table VI shows representative data obtained from the series reviewed and illustrates the diversity of problems encountered with regard to contraceptive regimen, menstrual history, endocrine evaluation, management and outcome of treatment.

TABLE V
INCIDENCE OF COMPLICATION COMPARED TO
AMOUNT OF PROGESTIN ONLY IN
CONTRACEPTIVE TABLET (WHEN KNOWN)

Progestin Content mgm	Number of Patients
10.0	6
5.0	27
4.0	12
3.0	0
2.5	4
2.0	8
1.0	6

Discussion

It is the general consensus that oral contraceptives exert their anti-ovulatory effect by suppression of pituitary gonadotropins. The estrogen component inhibits FSH secretion, and the progestin abolishes the mid-cycle LH peak.² Indeed, patients on oral contraceptives have been shown to ovulate when administered exogenous gonadotropins, *e.g.*, Pergonal, simultaneously. These regimens, however, are also known to alter the permeability of the cervical mucus, to exert specific effects on endometrial morphology and perhaps to interfere with sperm capacitation.¹⁰

The mechanism by which oral contraceptives exert their effect on gonadotropin secretion is not precisely known. However, it is generally agreed the hypothalamic-pituitary axis is involved—presumably through suppression of some hypothalamic center responsible for gonadotropin release.² The endocrinopathy which comprises prolonged amenorrhea and anovulation following cessation of contraceptive regimens is thus explained as the result of "over-suppression,"¹⁵ with the failure of the inhibitory ef-

TABLE VI
REPRESENTATIVE DATA SHOWING CONTRACEPTIVE, ENDOGENOUS ESTROGEN LEVELS, MANAGEMENT AND OUTCOME OF TREATMENT OF SELECTED PATIENTS

Age	27	27	27	31	23	22	26
Menstrual History	Irregular	Irregular	Regular	Regular	Regular	Regular	Irregular
Gravidity	0	0	0	?	0	0	0
Progestin	Noreth. Ac.	Noreth. Ac.	Comb.	Noreth.	Noreth.	Noreth.	Noreth.
(mg)	4	2	?	2	10 & 5	10	2
Estrogen	E.E.	E.E.		E.E.	EE3ME	EE3ME	EE3ME
(µg)	50	50		50	150	150	100
Duration Rx	3	7	48	24	31	9	9
Amenorrhea (months)	21	12	11	6	8	12	13
Endogenous Hormones							
Estrogen	Negative	Negative	Negative	Not Measured	Negative	Positive	Negative
Gonadotropin			Low				Low
Treatment	Clomiphene	Clomiphene—Pergonal	Clomiphene (100 mg)—Pergonal	Prednisone (10 mg)	Prednisone (10 mg—2 mo.) Pergonal (150 IU 10d)	Prednisone (10mg—7 mo.) Ovulen(1mo.)	Prednisone (10 mg) Ovulen
Results	Term pregnancy followed by amenorrhea	Term pregnancy	Ovulated(?)	Regular Menses	Pregnant	Pregnant	Male factor found

Abbreviations used in table: Noreth. Ac., Norethindrone Acetate; E.E., Ethinyl Estradiol; Comb., Combination product; EE3ME, Mestranol.

fect on the hypothalamus to be promptly reversed following discontinuance of therapy.

Endometrial changes have been most accurately described⁴ and, in combination regimens, have been shown to consist of the following:

- (1) In the first half of the cycle, with exogenous progesterone inhibiting estrogen-induced proliferative changes, a limited secretory activity is seen along with minimal proliferative activity;
- (2) In view of minimal glandular proliferation due to opposed estrogen early in the cycle, the secretory response in the latter half is accordingly limited.
- (3) In addition to this lag in development, a persistent pattern of glandular regression also has been observed.

It must be noted, however, the large number of observations which have been made are primarily morphological descriptions and do not indicate the underlying biochemical alterations which may have occurred in endometrial cells. Studies of endometrial enzyme systems following long-term therapy need to be conducted and the ability of these systems to respond to endogenous estrogen and progesterone following discontinuance of the synthetic agent must be defined. Furthermore, it is imperative to determine if these enzyme systems

have been altered so they are incapable of maintaining a pregnancy. Garcia and Wallach have reviewed many of the biochemical changes following long-term use of oral contraceptives.⁵

Inspecting the cumulative data of the eight authors whose studies have been reviewed, one can make several observations. First, this endocrinopathy seems as likely to occur in patients with no prior menstrual irregularities as in patients with irregular catamenia. Second, parous women as well as nulligravidas are affected. Third, there is no linear correlation with duration of contraception. Fourth, there appears to be no correlation with progestin dosage. In essence, it is extremely difficult to delineate or define any common denominator which would seem to predispose to this endocrinopathy.

Endocrine System Examination

The differential diagnosis of secondary amenorrhea due to oral contraception necessitates a complete examination of the endocrine system. A complete history and physical is obligatory. This should include evaluation of body configuration, acne or hirsutism, breast development, external genitalia, clitoris, uterus, and adnexa. Second, the severity of the endocrinopathy can be gauged by evaluation of endogenous estrogen levels. This can be accom-

plished by observing cornification of vaginal smears; amount, viscosity, spinnbarkeit, and arborization potential of cervical mucus; suction endometrial curettage and microscopic examination for proliferative activity; or demonstration of uterine bleeding following administration and withdrawal of a progestational agent, *e.g.*, medroxyprogesterone acetate (Provera, 10 mg per day for 5 days). If endogenous estrogen is low a skull film of the sella turcica to indicate pituitary integrity is indicated. Determination of urinary 17-hydroxycorticosteroids for adrenal cortical function and assessment of thyroid function also are in order. In the patient groups reviewed, 56 underwent evaluation of endogenous estrogens by a variety of the previously mentioned parameters, and 32 patients were found to have inadequate levels.

In the patient who presents with involuntary infertility but, with regular periods, one should consider the possibility of an anti-spermatozoa antibody formation from a cervix which has been chronically exposed due to the fact that a mechanical barrier method of contraception has not been employed.⁹ The demonstration of increased anti-spermatozoal antibody in women utilizing oral contraception has not been proven and may be considered conjectural at this time.

Treatment of the endocrinopathy finds the authors of the studies reviewed in three groups with respect to suggested therapeutic regimens; these being clomiphene, gonadotropins, and prednisone. Shearman¹⁵ treated 12 patients with clomiphene and experienced good results, *i.e.*, return of normal ovulatory cycles and/or pregnancy, in 11 of these patients. One of the 11 conceived, but amenorrhea followed delivery and had persisted for 24 months at time of publication. The one patient who did not respond to clomiphene had ovaries demonstrably sensitive to gonadotropin stimulation, and a FSH regimen was followed by pregnancy. His article, however, does not mention the dosage of clomiphene used, nor the duration of treatment. Spellacy¹⁷ experienced largely unfavorable results with clomiphene, which he utilized in five daily doses of 100 mg. Three of four patients thus treated did not respond (the fourth ovulated), but following treatment with exogenous gonadotropins (Pergonal and Antruitin-S) all ovulated and one conceived.

Use of Clomiphene

The rationale behind the use of clomiphene is apparently the same as involved in its choice for treatment of anovulation and fertility in general. Whether the mechanism involved is stimulation of the anterior pituitary and release of gonadotropins either directly or indirectly by means of an "anti-

estrogenic" effect is not entirely clear. In their recent communication, Homesley and Goss⁷ presented 13 cases of menstrual dysfunction following use of oral contraceptives. These authors described three basic patterns *viz.* anovulation/amenorrhea (nine patients), anovulation/irregular bleeding (two patients), and prolonged follicular phase (two patients). Their data demonstrate the ovulatory response in patients treated with clomiphene or HMG and HCG was excellent.

Prednisone was employed in two series,^{3, 8} both times in dosages of 5 mg. twice daily. Eight of 10 patients thus treated experienced favorable results. One of the refractory patients was then treated with Pergonal (HMG) and HCG and subsequently became pregnant. Horowitz⁸ does not indicate the duration of treatment in patients in his series, while Dodek and Kotz³ employed therapeutic regimens from two to seven months' duration.

The mechanism by which prednisone exerts its effect is also somewhat controversial. However, several authors report series showing increased urinary levels of gonadotropins in patients receiving adrenal cortical hormones,¹⁶ and one author postulates a selective increase in FSH secretion as the result of synthetic corticosteroid administration.

Conclusions

Amenorrhea and involuntary infertility following oral contraception is an infrequent phenomenon. It is seen more often in patients discontinuing combination regimens than in those who utilized sequential preparations. There are no readily discernible parameters that would screen "susceptibles" prospectively. However, although patients with both regular and irregular menses prior to treatment are involved, the representation of the latter group seems disproportionately high (18 of 82) and patients with irregular menses, who desire more children at a later time, might be better managed with sequential prophylaxis.

Finally, the endocrinopathy seems, fortunately, to be rather amenable to therapy, with variable results having been obtained with clomiphene, gonadotropins, and prednisone.

69 Butler Street, S.E.

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AMA LAUNCHES NEW COMMUNICATIONS PROGRAM

The American Medical Association is launching a special communications program in three national magazines and selected local media. Part of the effort will focus on better personal health care. Part will provide information on organized medicine's response to various national health care issues.

"The emphasis will be on education and information," Frank D. Champion, the AMA's Director of Communications, says. "We hope to make a positive, constructive contribution both to people's own personal health and to the growing public dialogue on national health care problems."

Present media plans call for six to eight full-page insertions in *Life*, the *Readers Digest* and *Ebony* during the remainder of 1971, possibly 10 insertions in major newspapers plus very limited exposure on television in a few cities. The budget currently provides for the expenditure of \$750,000 in 1971 and a similar amount in 1972.

Of the three messages now being released for publication one, with the headline "How to Kill Yourself," warns of the dangers of being overweight, while pointing out that "over 70 per cent of the AMA's annual budget goes for health and scientific information."

A second, on the subject of ecology, indicates that disease aggravated by environmental factors adds \$38 billion to the nation's health bill. The third, speaking more specifically to national health issues, talks about the AMA's student loan program. Since 1962 the AMA, through voluntary contributions by individual physicians, has guaranteed \$48 million worth of loans and helped 20,000 medical students, interns and residents to become practicing physicians. It also points out, in discussing the doctor shortage, that "While overall population has expanded 12 per cent since 1960, the U.S. physician population has grown 28 per cent."

The campaign was developed under the direction of the AMA Trustees' Committee on Communications, headed by John R. Kernodle, M.D., a practicing physician in Burlington, North Carolina and Vice Chairman of the AMA's Board.

PRACTICAL NURSING SCHOOLS REPORT

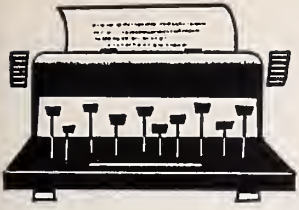
Practical nursing schools in the United States reported 53,080 students enrolled in October 1970, an increase of 4,738 over the previous year, according to a survey released by the National League for Nursing, New York.

The number of programs preparing practical nurses remained stable, with 1,253 in 1970 as compared with 1,252 in 1969, the survey revealed.

The higher enrollment figure thus reflects expansion in class size, indicating a growing interest in practical nursing as a career. Mrs. Margaret E. Walsh, NLN general director, stated. She pointed out that there has been a steady increase in the number of students preparing to become licensed practical nurses during the past decade.

Student admissions to practical nursing programs rose to 55,635 in the academic year 1969-70, or 6,528 more than the year before, the League indicated. During the same period, 37,128 men and women were graduated from practical nursing schools—2,264 more than for the preceding 12 months.

The League conducts annual surveys of nursing education programs as part of its effort to promote community planning for nursing.



Tuberculosis in Georgia—1971

TUBERCULOSIS, THE WHITE PLAGUE, the Great Killer, rampant for centuries, has been “slowed to a walk” in the past quarter century, the Chemotherapy Era. The recorded number of deaths from tuberculosis in Georgia plummeted from 1,048 in 1946 to 39 in 1967, for a death rate decline from 33.5 to 0.9 per 100,000 population. Only 47 deaths from tuberculosis were reported during 1970, again a rate of less than one per 100,000.

The decline in newly reported cases has been precipitous, too. There were 2,534 newly reported cases in Georgia in 1946 and 955 in 1970—a drop in morbidity rate from 80 to 20 per 100,000 population. While only 600 of the newly reported cases had positive bacteriology, nearly two-thirds of them had advanced disease. The early diagnosis of tuberculosis is still a myth.

Improved housing and economics have played a part in this decline. Major credit, however, must go to the use of the following nine drugs: streptomycin, isoniazid, para-aminosalicylic acid, pyrazinamide, cycloserine, ethionamide, viomycin, ethambutol and rifampin. Combinations of three or more of these drugs given to patients whose tubercle bacilli are drug susceptible result in bacteriologic conversion by smear and culture, in over 95 per cent of the patients with advanced disease, within the first six months of treatment. The spread of tuberculosis after the establishment of an adequate drug regimen for a few months is negligible. Lesser disease may be treated with two appropriate drugs.

Drug therapy has resulted in a reduction of the average period of hospitalization from around 500 days in 1953 to about 100 days in 1971. The per diem day cost has increased from about \$6.00 a day in 1953 to approximately \$30.00 a day in 1971. An average period of hospitalization costs around \$3,000—the same as in 1953. The trend for shorter periods of hospitalization and earlier discharge brings less certainty of bacteriologic conversion. A system of adequate clinics for medical follow-up is a necessity to complement the reduced hospital stay.

The relapse rate after completion of prescribed drug therapy is so low (2 per cent) that we are thinking in terms of cure of tuberculosis—not arrest. Those patients who relapse do so primarily because of a failure to continue on prescribed drug therapy. Supervised out-patient drug administration becomes paramount for a small minority of patients. The number of patients on the state tuberculosis register has been reduced from 8,000 to 4,000 in the last several years, incorporating newer ideas of management. This allows our resources to be utilized in the active treatment phases of the program where they are most needed.

Another positive factor is the utilization of chemoprophylaxis. Extensive field trials of the USPHS indicate that chemoprophylaxis can reduce morbidity from tuberculosis in high risk groups by 70 per cent during the year of medication and by nearly 50 per cent thereafter. Suggested guidelines for chemoprophylaxis have been distributed to all practicing physicians in the state of Georgia by the Georgia Tuberculosis and Respiratory Disease Association and the Georgia Thoracic Society.

School skin test surveys reveal we are rearing generations of practically non-infected children in Georgia.

Nevertheless, there is a reservoir of infected people, from which will come a decreasing, but steady number of cases to infect others before diagnosis and treatment is underway.

Although the tendency is to forget the disease, the time is not yet here to drop our guard against this wily enemy. Skin tests, x-rays and sputum examinations must still be done on sick, coughing patients as the ravages of the undiagnosed disease are tremendous.

*Raymond F. Corpe, M.D.
Battey State Hospital, Rome, Ga.*

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

June 21, 1971

HEADQUARTERS BUILDING EXPANSION: Authorized Siler Associates to conduct a feasibility study on the expansion of the Headquarters Office Building for a maximum cost of \$3,000 with the understanding that the study would be available for the September Council meeting. The Committee voted to reactivate the Building Expansion Committee and named F. G. Eldridge, M.D., Chairman and J. G. McDaniel and John S. Atwater as Committee members.

APPOINTMENTS: Committee on Private Practice; asked Chairman Donald R. Rooney to name five members and each District Society President to name one member. Committee on Communications; F. G. Eldridge, Chairman, with Subcommittee on Liaison with News Media, Thomas Cooper, Chairman, Alexis Davison and Linton Bishop; Subcommittee on County Society Officers Conference, J. Watts Lipscomb, Chairman, Tully Blalock and J. Norman Berry; Subcommittee on Liaison with County Societies, Donald Rooney, Chairman (Dr. Eldridge and Dr. Rooney to select additional subcommittee member); Third District Board of Health nominees to the Governor, James H. Sullivan, Floyd Jarrell and Robert C. Garrett; Federal Government Advisory Positions, authorized certification to AMA the names of W. C. Rhangos, Henry A. Brandt and Elliot A. Cobb, all of Savannah, and J. Rhodes Haverty, F. William Dowda, and John T. Mauldin, all of Atlanta; Committee on Medical Review and Negotiating, Joseph S. Wilson, member, and Edwin C. Evans, alternate, for Internal Medicine.

RADIOLOGICAL TECHNOLOGISTS: Referred this matter to Committee on Legislation; a request for appointment of a special Ad Hoc Committee to work with the Technologists to draft licensure legislation.

FOUNDATION CONTRACT: Received information on willingness of Board of Health to award Medicaid

contract to the Georgia Medical Care Foundation, and approved the appointment of F. G. Eldridge as MAG representative to Cost Control Committee created by the Board of Health.

ALLIED HEALTH PERSONNEL INVENTORY: Agreed to participate in Comprehensive Health Planning project through all-member mailing at OCHP expense.

LIAISON COMMITTEES: Received President's report that he will appoint the four most recent Past Presidents to study MAG Committee structure; the Presidents of all recognized specialty societies to an Interspecialty Council; and request Subcommittee of Committee on Education to liaison with medical students.

FUTURE MEETING DATES: Executive Committee on July 18, 9:00 a.m., MAG Headquarters, and August 8, Biltmore Hotel in conjunction with Committee Conclave.

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THROUGH THE CLOVER LEAF

IT WOULD BE OLD-FASHIONED and trite with all the changes taking place to say that medicine is at the cross roads. In this age of high speed and super highways, it would be more fitting to say that we have come to the clover leaf and it's hard to know just which of the many turns we should rightly make.

With this in mind, I think it is interesting to recall a part of the speech that Mr. Robert J. Myers made in the spring of 1970 to the Oklahoma State Medical Association's annual meeting. Mr. Myers at that time was chief actuary for the Social Security Administration. In his speech, Mr. Myers stated: "The physicians of this country have been neatly trapped by the social planners who criticize them on any possible grounds. Medicare's intent was that the aged should pay the same medical fees as the young, and that they should not be second class citizens treated at charity rates. Now that the physicians have charged in this manner, they are severely criticized. If the medical profession had artificially held down fees for Medicare, the social planners would have pointed out the program was working so well and cheaply that it should be extended to the whole population. You can't win.

"Mutual trust and confidence should be generated between profession and government. This certainly does not exist now, and for good cause. After lying low for two decades, during which they sought to get the camel's nose in the tent through the enactment of Medicare, they are now using their appealing argument, the increases in Medicare costs, to justify more controls. Medical science has been making giant steps of progress, and the health and longevity of the American public is at an all-time high. Yet the advocates of socialized medicine are raising their voices to denigrate the existing medical situation and are clamoring for a National Health Insurance. There are people in government who look toward the eventual control of physicians' fees on a very stringent and different basis than was originally envisioned."

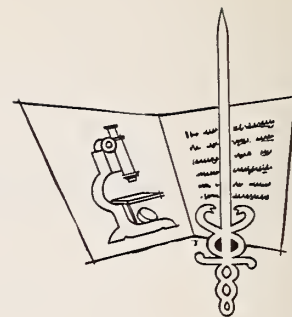
These were brave words coming from one within the department. Mr. Myers was relieved of his connection with Social Security soon after this. It appears that freedom of speech and truthful opinions, if different from those who make the rules, aren't tolerated in this department.

Mr. Myers is now Actuarial Consultant to the American Medical Association. He appeared, as you remember, on the panel at our recent Annual Session and did a commendable job of refuting many of the claims and statements of the other two panelists, Mr. Wilbur Cohen and Dr. R. O. Egeberg. I think we should all be glad that Mr. Myers is on our team to help us find our way out of the cloverleaf.

Until next month,

A handwritten signature in cursive script that reads "W. C. Mitchell".

W. C. Mitchell, M.D.
President, Medical Association of Ga.



CURRENT CONCEPTS IN MANAGEMENT OF HODGKIN'S DISEASE

JOHN P. WILSON, M.D., *Atlanta*

AT A RECENT WORKSHOP on lymphoma-leukemia held at the Memorial Medical Center, Savannah, Ga., sponsored jointly by the Georgia Regional Medical Program and the American Cancer Society, it was pointed out that some of the more recent concepts in the management of Hodgkin's disease are still not generally familiar to many physicians.

Improvements in management have centered around three primary factors: (1) the reclassification of Hodgkin's disease, (2) a more specific method of staging, and (3) improvement in radiation and chemotherapy.

The reclassification of Hodgkin's disease in 1966 by Lukes¹ into four categories, (1) lymphocytic predominance, (2) nodular sclerosis, (3) mixed cellularity and (4) lymphocytic depletion, allowed a more specific prognostic and clinical behavior pattern to be determined.

The principal distinguishing feature of Hodgkin's disease within the group of lymphomas is the concept of its spread by contiguity. Because of this characteristic, staging of Hodgkin's disease becomes not only a practical but essential part of its proper management.

Stages of Disease

Although there are individual modifications, the basic staging as reported by Rosenberg² is as follows:

Stage I. The disease is limited to one anatomical region or two contiguous regions on the same side of the diaphragm.

Stage II. The disease involves more than two or two non-contiguous regions on the same side of the diaphragm.

Stage III. There is disease on both sides of the diaphragm but not extending beyond the involvement of lymph nodes, spleen and/or Waldeyer's ring.

Stage IV. There is involvement of the bone marrow, lung, pleura, liver, bone, skin, kidneys, G.I. tract or any tissue organ in addition to the lymph nodes, spleen or Waldeyer's ring.

Each of these stages is classified A or B, to indicate the presence or absence of systemic symptoms; that is, fever, night sweats or pruritus.

Laparotomy Utilization

The most notable change and improvement in staging in recent years has been the use of a more specific approach. For several years venography and lymphangiography have been relied on a great deal for determination of the extent of involvement. Recently there has been a trend to utilize laparotomy in the staging of Hodgkin's. This was precipitated by several studies and a composite evaluation of these has been made by Ultmann³ with the following features:

(1) Biopsy of the periaortic nodes. In the study of Ultmann the evaluation of

the reliability of venography and lymphangiography showed that in 74 patients with negative studies, nine had infradiaphragmatic involvement, seven of these in areas not usually included in the radiation field, and of 71 patients with positive or equivocal studies only 34 had had a positive diagnosis, and four additional cases had involvement outside the normal area of therapy.

(2) Multiple liver biopsies, needle and wedge. Of 152 liver biopsies, four of 120 not suspected of having liver involvement were positive and three of 32 thought to be involved were actually negative.

(3) Splenectomy. In 182 splenectomies, 66 were found to be involved, 38 being preoperatively suspected. It was found that there was no consistent relationship between involvement and the size of the spleen. Removal of the spleen provides a positive diagnosis regarding involvement, eliminates the need for irradiation of the spleen thereby decreasing total irradiation, and eliminates the possibility of hypersplenism which is frequently a complication and in particular the development of hemolytic anemia.

Treatment Determinations

The place of the major modalities of treatment, surgery, radiation and chemotherapy generally have been determined to be as follows:

(1) Surgery. In the past, radical node resection has been utilized in the treatment of Hodgkin's disease. Today, radical regional node dissection is not indicated. The place of surgery in Hodgkin's disease is limited basically to diagnosis and staging.

(2) Radiation. Radiation therapy is the basic treatment in Hodgkin's disease. The recent aggressive approach with radiation therapy has resulted in high five-year survivals. In particular, the "extended field" approach or "mantle" technique for above the diaphragm and "inverted Y" below the diaphragm, and the combination of the two or "total nodal irradiation" as has been used by Kaplan,^{4, 5} Johnson⁶ and others has resulted in five-year relapse-free survival rates of 80 per cent in Stage I-A and II-A. Seventy per cent survival rate in I-B, II-B and III-A can be anticipated. Extended field therapy alone or followed with combination chemotherapy should yield a 40 to 50 per cent five-year survival.

(3) Chemotherapy. Chemotherapy in Hodgkin's continues to undergo constant change, evaluation and extensive use. The drugs currently used include Cyclophosphamide (CTX), Vinblastine (VLB), Nitrogen Mustard (HN2), Procarbazine (MIH), Vincristine (VCR), BCNU (NSC-409962), L-asparaginase, and Dibromodulcitol (NSC-104800). Combination therapy is usually given, the most widely used regimen being some variation of the MOPP program which includes a combination of Mustargen (nitrogen mustard), Oncovin (Vincristine), Procarbazine and Prednisone. In combination therapy Procarbazine appears to be the most important drug in achieving a high remission rate.

Many investigational studies combining various chemotherapeutic agents and radiation therapy are currently being carried out and will continue to appear in the literature in the next few years. It is important that the practitioner remain knowledgeable in this rapidly progressing and improving area of cancer control.

340 Boulevard, N.E. 30312

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FAT EMBOLISM—A CARDIOPULMONARY CATASTROPHE

C. DANIEL CABANISS, M.D., *Columbus*

FAT EMBOLISM has been a source of confusion to clinicians and pathologists since its description as a disease entity. The clinician is confounded by the difficulty of diagnosis and treatment and the pathologist by the difficulty of correlating pathophysiology with the morbid anatomy.

In many cases of traumatic fat embolism it appears that globular fat is initially released from bone marrow fat cells and travels via the lymphatic and/or venous channels to lodge in the lungs. The finding of marrow elements in areas of fat embolism supports this mechanism. Certain observations, however, suggest that other mechanisms may be operative. Considerable qualitative difference exists between the fat found in the lungs and normal marrow fat. Fat embolism also occurs in conditions other than fracture of long bones; e.g., diabetes mellitus, sickle cell crisis, bacterial infection, alcoholism, certain types of poisoning and immuno-suppressive therapy. These conditions have in common cellular injury that may release free fatty acids from adipose tissue and increases the synthesis of very low density lipoproteins from the liver. These compounds are unstable and coalesce to contribute to embolic fat. Another theory holds that the common denominator in traumatic fat embolism is hypovolemia induced by considerable blood loss into fracture sites. The "wash-out" of large amounts of fat from trauma sites under conditions of hypovolemia and shock has been demonstrated.

The typical patient with fat embolism usually demonstrates a 24 to 48 hour "problem free" period following the initial insult. This is followed by extreme tachypnea out of proportion to pulmonary findings and then the variable appearance of central nervous system symptoms, high fever, extreme tachycardia, and petechiae. Late manifestations are hypotension and a falling hematocrit.

Aids in diagnosis and therapy include: 1) arterial blood gases and pH (demonstrating severe hypoxemia with respiratory alkalosis early in the course and followed by respiratory acidosis), 2) blood volume, 3) chest films (showing a pattern of alveolar pulmonary edema), 4) urine and sputum examination for fat, and 5) fundoscopic examination for the demonstration of fat in the retinal vessels.

Treatment for this condition is at present not wholly satisfactory, but a suggested plan of management would involve:

1. Blood volume replacement
2. Monitoring of central venous pressure as a guide to replacement therapy
3. Vigorous correction of acidosis
4. Oxygen
5. Heparin in sub-anticoagulant dosage to stimulate lipoprotein lipase
6. Digitalize if right heart failure is present

Vigorous correction of hypovolemia and prevention of shock following long bone fracture may prevent the development of this life threatening condition.

Medical Center 31902

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



WORLD-WIDE EXPERTS

JOHN L. MOORE, JR., *Atlanta**

THE SUPREME COURT OF MICHIGAN, in November, 1970, handed down an important decision changing earlier concepts as to the standard of practice required of experts in the medical field.

Facts of Case

John Francis Naccarato, as a baby, was in the treatment of two Board certified pediatricians in Detroit in 1960. Those pediatricians failed to discover and diagnose John's condition as phenylketonuria (PKU).

In the trial court the judge allowed Dr. David Hsia of Chicago, Ill., and Dr. Richard Koch, a pediatrician of Los Angeles, to testify that any Board certified pediatrician should have tested for PKU in 1960. Dr. Hsia said:

"... that any resident who has been trained and who is a certified pediatrician would be expected to be, in a hospitalized patient anywhere in the country, to routinely test for phenylketonuria as part of a mental retardation workup in a hospital. I don't think anyone in 1960, I mean whether this is in Detroit or Chicago or in Oshkosh, it doesn't really make any difference. This is the established standard for anyone who is a board certified pediatrician, period."

John suffered a significant degree of mental retardation and the jury in the trial court awarded damages in the amount of \$80,000.

On appeal the intermediate appellate court reversed the trial court on the ground that it should have admitted as experts only physicians familiar with the standard of practice of pediatrics in the Detroit area.

Decision of Michigan Supreme Court

The Supreme Court of Michigan overturned the decision of the intermediate appellate court. The court indicated that its decision was quite narrow, only as to who might testify in a trial, as distinguished from what the standard of practice to be imposed on practitioners is. The court said:

"It is unnecessary at this juncture to re-examine whether the practice of the community should be the standard to which all area general practitioners should be held. Rather, at issue here is the competency of acknowledged experts to testify as to the practice of a pediatrician, a specialist, in diagnosing and treating PKU."

The Supreme Court of Michigan stated that calling a specialist parochial or bucolic is hardly appropriate. The court further said:

"Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony."

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

Comment

Should other courts in the land follow the reasoning of the Supreme Court of Michigan, it is clear that specialists will be held to the standards of practice all over the country in medical centers rather than to the particular standard of practice in the particular community in which the physician practices.

Naccarato v. Grob, 384 Mich. 248, 180 N.W. 2d 788 (1970).

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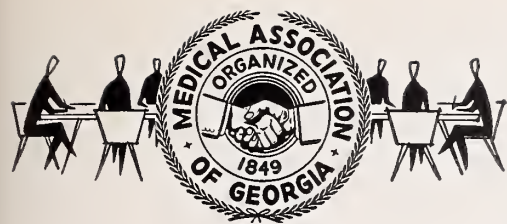
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Gallostra, Juan A. Active—Cobb—I	644 Cherokee Street Marietta, Georgia 30060
Garfield, Herbert I. Active—Clayton-Fayette— GP	217 Arrowhead Blvd. Jonesboro, Georgia 30263
Gerson, Gordon N. Active—Cobb—Or	969 Cherokee Rd., S. E. Smyrna, Georgia 30080
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Justice, Oren W. Active—Walker-Catoosa- Dade—GP	LaFayette Medical Center LaFayette, Georgia 30728
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Scharf, Forrest L. Active—Peach Belt—Path	110 Hospital Drive Warner Robins, Georgia 31093
Setzer, Edward H. Active—Stephens—I	800 E. Doyle Street Toccoa, Georgia 30577

SOCIETIES

The **Hall County Medical Society** has been instrumental in establishing and equipping the Northeast Georgia Speech and Hearing Center.

PERSONALS

First District

Leon E. Curry has been certified by the American Board of Family Practice as a Diplomate of the American Board of Family Practice.

Third District

J. C. Serrato, Jr., was elected as a trustee to the Pan American Development Foundation, Washington, D.C., in May. Dr. Serrato is the first Georgian and southerner to be elected to such a position.

Fifth District

Bedford Davis will accompany a group of physicians, dentists and young people from the Northside Drive Baptist Church on a missionary venture into Honduras this summer.

Gerald F. Fletcher and **Colon H. Wilson, Jr.**, have been named Fellows of the American College of Physicians.

John T. Godwin has been re-elected President of the Health Careers Council of Georgia, Inc.

Joseph Hertell was guest speaker at Cobb General Hospital in May. His topic was "The Trip There and Back," concerning drug abuse.

Hugh S. Thompson directed a three-day course on emergency care and transportation of sick and injured persons at the Atlanta Area Technical School in June.

Seventh District

George T. Mims has been named a Fellow of the American College of Physicians.

James L. Oosterhoudt spoke on drug abuse at the April meeting of the Parent-Teacher Association of Dug Gap School, Dalton.

Eighth District

Arturo Gonzalez has been elected into active membership in the American Academy of General Practice.

Tenth District

Zachary M. Kilpatrick has been named a Fellow of the American College of Physicians.

DEATHS

Edwin T. Arnold, Jr.

Edwin T. Arnold, Jr., died at his home in Hogansville on May 8, 1971.

A graduate of the University of Georgia and the University of Chicago Medical College, Dr. Arnold had practiced medicine in the West Georgia area since 1938.

He was a member of the Troup County Medical Association, the Medical Association of Georgia and the American Medical Association. He was a member, deacon and Sunday school teacher at the First Baptist Church of Hogansville. He was a member of the Hogansville Lions Club and a former member of the Hogansville Board of Education.

Dr. Arnold served during World War II in the medical corps.

He is survived by his widow; a daughter, Mrs. Ellen Burke of Valdosta; sons, Edwin T. Arnold, III, of Griffin, Richard Arnold of Hogansville, and Frank Arnold of Athens; father, Edwin T. Arnold of Washington, Ga.; a sister, Mrs. Hope Hammond of Griffin and one grandson.

Walter Holloway Bush

Walter Holloway Bush, a prominent Macon physician and staff member of several Macon hospitals, died June 6 in his home of an apparent heart attack. He was 60 years old.

ASSOCIATION / Continued

Born in McKinney, Tex., Dr. Bush was a graduate of Texas Christian University in Fort Worth and the University of Texas Medical School in Galveston.

He was a veteran of World War II, serving in the China-Burma-India theater. While in India he attended the India Malaria Institute at Delhi and was the first American to complete the course. He graduated with top honors in his class.

A former staff member of the Baylor University School of Medicine, Dr. Bush had practiced medicine in Macon since 1947.

He was a member of the Bibb County Medical Society, Medical Association of Georgia and the American Medical Association.

Dr. Bush was a member of Phi Chi and Alpha Omega Alpha medical fraternities, the Idle Hour Country Club, the Macon Elks Club and St. Paul's Church.

He is survived by his widow, a daughter, a son, his parents and two sisters.

William Walter Chrisman

William Walter Chrisman died May 5 in a Macon Hospital.

A native of Williamson County, Tenn., Dr. Chrisman attended Vanderbilt University Medical College, interning at Vanderbilt Hospital and taking his residency at Baltimore City Hospital, Baltimore, Md. He moved to Macon in 1929 and was associated with the late Dr. Charles C. Hinton.

Dr. Chrisman was a Fellow of the American College of Physicians and a member of the American Medical Association, Medical Association of Georgia, Bibb County Medical Society and the Air-Medics Association.

He served on the staff of the Middle Georgia and Macon hospitals and was staff physician for the Appleton Church Home. He was Senior Aviation Medical Examiner for the Federal Aviation Administration.

Dr. Chrisman was a Mason, a member of the Elks Club, the Exchange Club, the Satilla River Club and the First Christian Church. He was past president of the Vanderbilt Alumni Association.

He is survived by his widow, Mrs. Selma Lane Chrisman; a daughter, Dr. Anne Hanse, two grandsons, William Chrisman Hanse and George Albert Hanse, IV, all of Macon; two sisters, Mrs. W. R. Graves and Mrs. P. K. Dwyer; two brothers, J. L. Chrisman and P. H. Chrisman; a half-brother, Paul Chrisman, all of Nashville, Tenn.

R. Cullen Goolsby

R. Cullen Goolsby, 74, died April 6 in a Macon hospital.

A native of Monroe County, Ga., Dr. Goolsby attended Emory at Oxford and Emory University. He did specialized training at Tulane University and after practicing in Forsyth nine years, moved to Macon in association with the late Dr. Ben Bashinski.

Dr. Goolsby was a Fellow of the American Academy of Pediatricians, member of the American Medical Association, Medical Association of Georgia, Bibb County Medical Society and the Sixth District Medical Society.

He served on the staff of the Macon and Middle Georgia hospitals. He was a Mason and a Shriner, as well as a member of the Idle Hour Country Club and Vineville Methodist Church.

Dr. Goolsby is survived by his widow, Mrs. Margaret Kirven Laney Goolsby; two daughters, Mrs. Margaret Greer of Macon and Mrs. Arthur B. Hammond of Spartanburg, S.C.; a half-sister, Mrs. L. E. Ellis of Claremont, N.H.; and several grandchildren.

Thomas Pinckney Waring, Jr.

Thomas Pinckney Waring, Jr., 54, who was an orthopedic surgeon in Savannah, Ga. for 20 years before moving to Baraga, Mich. in 1970, died May 15 of an apparent heart attack in Michigan.

A native of Savannah, he owned and operated the Oglethorpe Sanitorium from 1949 until it closed in 1970.

Dr. Waring attended the Washington and Lee University, receiving his medical degree from the University of Michigan Medical School.

A veteran of World War II, Dr. Waring founded an antique gun club in Savannah as well as a sports car club. He was a Fellow of the American Academy of Orthopedic Surgeons, a member of the American Medical Association, Medical Association of Georgia and the Georgia Medical Society.

Dr. Waring belonged to the Oglethorpe Club and the Savannah Yacht Club.

He is survived by his widow; a sister, Mrs. Alice Stetson of Savannah; a nephew, Frank Stetson of Savannah; a great-nephew and numerous cousins.

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THE MONTH IN WASHINGTON

The House Ways and Means Committee has approved the Social Security Amendments of 1971 (medicare and medicaid changes) and sent the massive health bill to the floor of the House for expected early passage.

As adopted by the committee, the bill concerns itself with the implementation of the Administration's Health Maintenance Organization option for medicare beneficiaries, restricts physicians' fee increases under federal programs, reduces some long-term medicare benefits, and covers under Medicare for the first time disabled social security beneficiaries.

The Secretary would also be authorized to conduct experiments with areawide or communitywide peer review, utilization review, and medical review mechanisms.

Congress failed to pass substantially the same bill during the last session due to major differences between the House and Senate versions and the lack of time to reach agreement.

Provisions

Medicare beneficiaries would be permitted to have all covered care provided by a Health Maintenance Organization (HMO), defined as a prepaid group health or other capitation plan with the government reimbursing the HMO's at 95 per cent of the average cost of medicare beneficiaries in the area.

Physicians' medicare fees would be pegged at the 75th percentile of actual charges in a locality and future increases would be tied to a special index reflecting rising costs. The Department of Health, Education and Welfare could terminate payments to providers found guilty of program abuses.

A medicare co-insurance factor one-eighth of the hospital deductible would be applied after the 30th day. The medicare part B deductible would rise to \$60 a year and medically indigent persons above the poverty level could be required by the states to pay an income-related premium.

Other Features

Other features of the proposed legislation:

—HEW would be required to develop experiments and demonstration projects designed to test payment to providers of services on a prospective basis under the medicare, medicaid, and maternal and child health programs.

—Limits on institutional provider costs to be recognized as reasonable under medicare could be imposed based on comparisons of the costs of covered services by various classes of providers in the same geographical area.

—Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless a bona fide private patient relationship had been established or the hospital had, in the 2-year period ending in 1967, and subsequently customarily charged all patients and collected from at least 50 per cent of patients on a fee-for-service basis. Medicare payments could also be authorized on a cost basis for services provided to hospitals by the staff of certain medical schools.

—HEW would be authorized to establish minimum periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to require extended care level of services in an extended care facility. The attending physician would certify to the condition and related need for the services. A similar provision would apply to post-hospital home health services.

—Present penalty provisions relating to the making by providers of care of a false statement or representation of a material fact in any application for medicare payments would be broadened to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral. The penalty for such acts, as well as the acts currently subject to penalty under medicare, would be imprisonment up to one year, a fine of \$10,000, or both. Similar penalty provisions would apply under medicaid.

—HEW would conduct a two-year study of the desirability of covering chiropractors' services under medicare.

The bill allows the HEW Secretary to authorize experiments with methods of medicare reimbursement or payment, "with areawide or community-wide peer review, utilization review, and medical review mechanisms," and with performance incentives for intermediaries and carriers.

Another section of the catch-all bill of wide public interest would establish a new family assistance welfare plan. The bill also increases social security case benefits and taxes.

Personnel Bill

The House Committee on Interstate and Foreign Commerce has approved a three-part health bill designed to meet the national shortage of medical personnel by 1978.

The proposed legislation would authorize an estimated \$3.3 billion in aid to health profession students and their schools in the next three years and provide the facilities and programs to close the manpower shortages in the health professions within seven years.

The nation's financially beleaguered medical schools would receive \$11,500 for the full-term cost of training each student, an action long urged by the American Medical Association. Saying that the measure was "long overdue," Congressman Paul Rogers (D., Fla.), chairman of the Subcommittee on health, predicts that the legislation will not only solve the shortage of health personnel by 1978, but will provide the necessary groundwork needed if Congress should approve some form of national health insurance.

Grant to Schools

Under the legislation, expected to pass the house in substantially the same form, each school would receive \$2,500 per student per year for the first three years of training. The grant rises to \$4,000 for the final year. In order to encourage swifter training, three-year schools would receive the same total as four-year schools, but the final year figure would be \$6,500.

Each school must enroll an additional five per cent of students, or 10 (whichever is the greater), to qualify for assistance. An extra \$1,000 will be awarded schools for each student exceeding this total. The measure will also help establish at least five new medical colleges.

Additional authorizations would provide \$270 million for health manpower initiative awards to establish health education centers, and \$412 million for special project grants for programs in family medicine, physician assistant training, and others. The bill continues support for scholarship and student loans at increased levels.

IRS Survey

An Internal Revenue Service survey of 8,400 health care providers who participated during 1968 in medicare and medicaid, including physicians and dentists, revealed that 83 per cent reported their receipts correctly.

Fifteen per cent of all taxpayers in the study under-reported receipts by an average of \$7,700, according to the IRS, and two per cent over-reported, by an average of \$16,000.

The survey was based in the main on providers of care who, as individuals, received \$25,000 or more from federal programs. Some 15,000 providers were involved in the study; however the 8,400 studied in detail were selected by a "scientific sampling process," the IRS said.

Forty-seven cases have been referred to the intelligence division for preliminary or full scale tax fraud investigation. However, the IRS spokesman pointed out that these results do not necessarily hold true for the entire health care profession.

The Justice Department has cracked down on the widespread abuse of "pep pills" by proposing the reclassification of amphetamines and methamphetamines so as to require that they fall in the category of non-refillable prescriptions.

The action would regulate amphetamines and methamphetamines as narcotic substances such as morphine, codeine, and opium as they carry a potential for "severe psychological dependence" with "serious danger" to abusers.

Manufacturing quotas geared to estimated legitimate use and the filing by manufacturers of order forms would be required. However, at least one major manufacturer has endorsed the proposal.

Some lawmakers have complained that Justice did not go far enough and that the order should have included phenmetrazine (Preludin) and methylphenidate (Ritalin).

Presidential Appointment

Commenting on the appointment of Merlin K. Duval, M.D., by President Nixon as Assistant Secretary of Health and Scientific Affairs, Department of Health, Education and Welfare, American Medical Association President Walter Bornemeier, M.D., said the AMA "enthusiastically endorses" the selection.

Dean of the University of Arizona College of Medicine and former professor of surgery, Dr. Duval, 48, succeeds Roger Egeberg, M.D., who remains as a consultant on health at the White House and as a special assistant to the HEW Secretary.

Dr. Duval is a member of the AMA's Committee on Undergraduate Medical Education and the Liaison Committee on Medical Education. A graduate of Dartmouth College and Cornell University Medical School (1946), he is a board certified surgeon.

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President Nixon recently signed into law a \$6.9 billion supplemental appropriation bill containing an additional \$100 million for cancer research. The "cancer cure" program would have an independently budgeted research unit within the National Institute of Health with a director reporting directly to the President.

"As I have said before, the time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dread disease," Nixon said in a statement.

Elliot Richardson, Secretary of Health, Education and Welfare, commenting on the President's action, remarked:

"I might just say briefly that what has been recognized here is the need for and the opportunity for a degree of the kind of managerial focus that has been effective in marshaling resources in other fields."

"There is a distinction, of course, as the President pointed out in his health message and elsewhere, between this situation and the moon shot in the sense that there is a need and an opportunity for the development of new knowledge. But at the same time . . . there is an opportunity also for the exercise of a central directive authority particularly in those aspects of the work that can be targeted and handled by contract, rather than grants with individual scientists."

Social Security Commissioner Robert Ball in a recent address on the concept of Health Maintenance Organizations listed six conditions that he considered essential to their success. The first condition, in Mr. Ball's estimation, was that "this way of practicing medicine must be made attractive to large numbers of physicians."

In elaborating on this point, Mr. Ball said:

"Successful organizations of any kind depend upon high staff morale. Thus, no health care system will work well that is not reasonably satisfactory to the key profession in that system. Physicians must be attracted to health maintenance organizations and they must feel good about what they are doing. High physician morale is by no means solely a matter of adequate compensation, although adequate compensation is important. The physician must be convinced of his ability to practice good medicine and to be generally free of bureaucratic constraint on professional judgment. Incidentally, it seems strange to me that the matter of physicians' likes and dislikes are so frequently overlooked by health care planners. We worry a lot about the morale of the armed forces, of school teachers and other government employees; in the health care system we better worry about the morale of the providers of care."

GEORGIA HEART SESSIONS FOR PROFESSIONAL NURSES FEATURE TOP FACULTY

The Georgia Heart Association's 1971 Scientific Sessions for Professional Nurses, September 17-18, at the Marriott Motor Hotel, Atlanta, will feature a prominent faculty in the field of cardiovascular disease.

Nine authorities will discuss the anatomy and physiology of the heart, nursing interventions based on scientific principles, the community approach to hypertension, target organ damage from hypertension, what we don't know about coronary disease and will evaluate patient teaching.

The sessions are presented on a clinical level for professional nurses involved in care and treatment of cardiac patients.

Faculty members are: Edward Dorney, M.D., Professor of Medicine (Cardiology), Emory University; Rose George, R.N., Assistant Professor of Nursing, Assistant Professor of Public Health, University of North Carolina.

Majorie Hewett, R.N., Head Research Nurse, Division of Clinical Pharmacology, Department of Medicine, Grady Memorial Hospital; J. Willis Hurst, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine.

Anita Johnson, R.N., Nurse Supervisor, Atlanta Community, High Blood Pressure Program; Connie R. Robinson, R.N., Assistant Professor, School of Nursing Medical Center, University of Alabama at Birmingham.

Mark E. Silverman, M.D., Assistant Professor of Medicine, Emory University; Elbert P. Tuttle, Jr., M.D., Professor of Medicine (Nephrology and Inorganic Metabolism), Emory University and Joseph A. Wilber, M.D., Director of Cardiovascular Disease Control Service, Georgia Department of Public Health.

Professional Nurses wishing to register for the sessions should contact the Program Department of the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta, Georgia 30324.

STATEMENT ON VENEREAL DISEASE

The American Medical Association Council on Environmental and Public Health reports that gonorrhea ranks first and syphilis third among the reportable communicable diseases in the United States. For the year ending June 30, 1970, infectious syphilis rates were eight per cent higher nationally than a year earlier, with annual increases spread over 33 states and an estimated incidence between 70-80,000 reported cases; there are 250,000 cases of all forms of syphilis estimated to be diagnosed and treated each year.

At the same time, gonorrhea morbidity exceeded 573,000 reported cases. Gonorrhea is pandemic in the United States, with an estimated two million cases.

The Council urges medical societies to acquaint their membership with the growing and alarming dimensions of the VD problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

Physicians in private practice treat approximately 80 per cent of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea they treat. Physicians should assist public health departments by reporting the VD cases they treat. Medical societies are

urged to cooperate and give broad support to public health authorities. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea.

The Council also urges medical societies to continue efforts for the enactment of state laws to permit physicians legally to treat VD cases of minors without obtaining parental consent; 29 states and the District of Columbia now have laws which permit physicians to treat a minor for VD without adult consent.

The American Medical Association is making VD a national theme for Community Health Week—1971, with suggested dates of October 17-23. Informational and promotional material will be available for medical societies. The AMA publication *PR Doctor*, January 1971, featured the problem of venereal disease, which included reports of excellent programs underway by state medical societies.

The Council encourages the publication of more articles in professional journals on venereal disease and its control for the guidance of the profession. Medical societies are asked to support education of patients and the public through more extensive and imaginative use of all available media and through school curricula.



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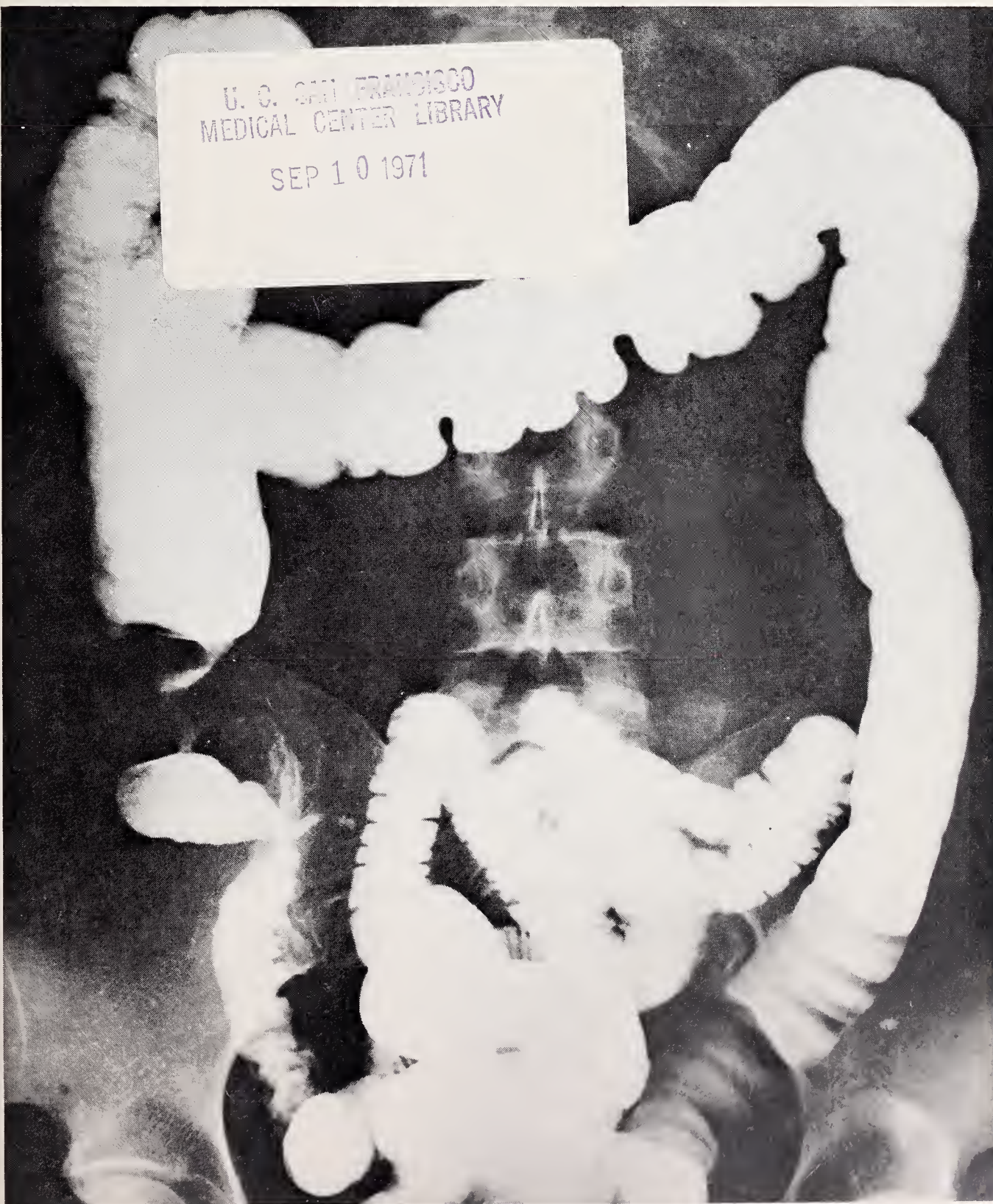
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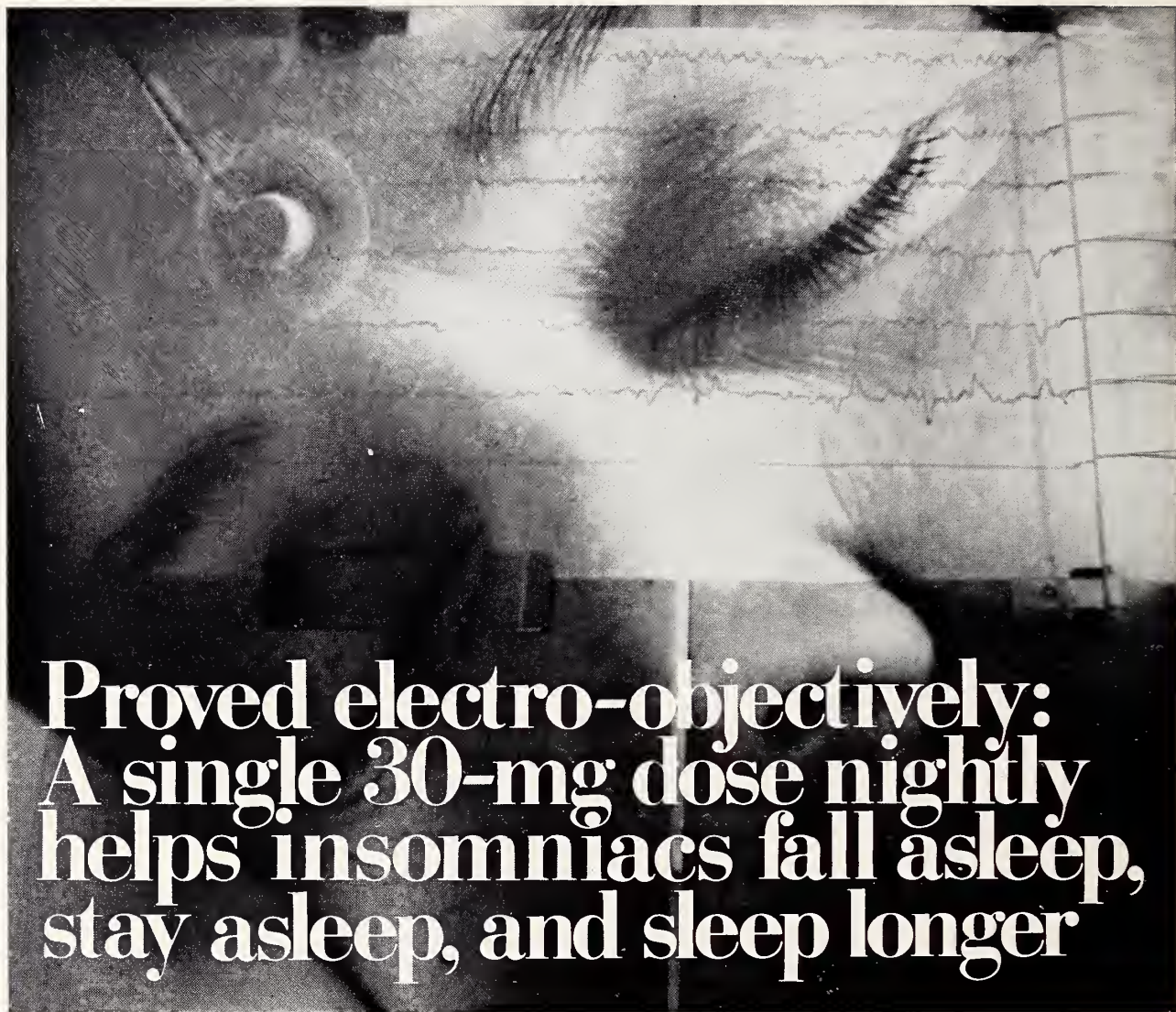
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Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.^{1,2,3}

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,¹ Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

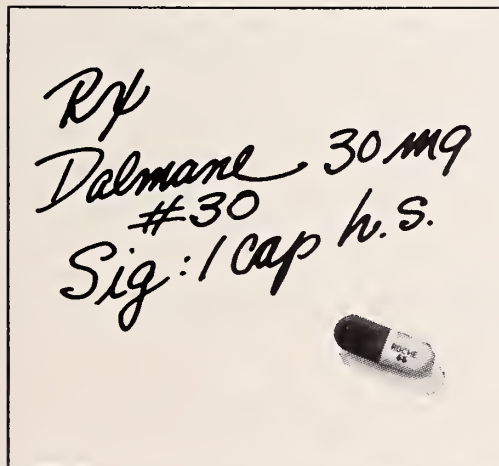
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.³ Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., et al.: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. 2. Kales, A., et al.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology*, Phila., Lippincott, 1969, p. 331. 3. Data on file, Medical Department, Hoffmann-La Roche Inc.



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Before prescribing, please consult Complete Product Information, a summary of which follows:

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.



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Photograph courtesy of Department of Medical Illustration, Grady Memorial Hospital. Layout by Robert Hamill, Atlanta.

Radical surgery may be avoided by the use of repeated barium enemas and sigmoidoscopy.

Benign Lesions of the Right Colon

THOMAS F. LEAR, M.D., STEPHEN W. GRAY, Ph.D., JAMES H. MILSAP, M.D. and
JOHN E. SKANDALAKIS, M.D., Ph.D., F.A.C.S., Atlanta

MANY BENIGN CONDITIONS occur in the right colon, and the differential diagnosis of these lesions is frequently difficult. This report concerns seven patients seen at Piedmont Hospital in the past six years, whose ultimate diagnoses illustrate several of the many benign conditions which may occur in the right colon. Patients with acute appendicitis have not been included in this report, nor have those with neoplasms which are frequently malignant such as carcinoid and polyps.

Astler, et al.¹ have divided benign lesions of the right colon into four groups as follows:

1. Benign neoplasms (benign variants of carcinoid hemangiomas, lymphangiomas, lipomas, fibromas, adenomas, etc.).
 2. Inflammatory and parasitic conditions (regional enteritis, mucocoele of appendix, ameboma, tuberculoma, actinomycosis, etc.).
 3. Anatomical and congenital abnormalities (diverticula, hypertrophic mucosal folds, inverted appendiceal stump, etc.).
 4. Physiological defects (hypertrophied ileocecal valve, fecalith, prolapsed ileal mucosa, etc.).
- The grouping is not exclusive, and a lesion may fall into more than one class. A benign neoplasm such as a lipoma may involve the ileocecal valve,

and this may become ulcerated and produce a non-specific inflammatory mass (Case 1).

In Table 1 the pre- and postoperative diagnoses of the seven cases are presented. Each of Astler's groups is represented by one or more cases. One patient had an acute abdomen on admission (Case 6). All other patients had a barium enema prior to surgery. Two patients (Cases 5 and 6) with inflammation of the cecum had previously undergone appendectomy. In all but one case the preoperative diagnosis was wrong and was more grave than the postoperative findings justified.

Case Reports

GROUP 1. BENIGN NEOPLASMS

Case 1. This 51-year-old woman was admitted with abdominal pain, abdominal distention and diarrhea. Her previous surgery included an appendectomy, and she had had pulmonary tuberculosis in the distant past. A barium enema showed a rounded filling defect in the region of the ileocecal valve. Another barium enema was done a week later which showed a small amount of barium on the ridges of the mass (Figure 1). The radiologist was somewhat concerned by the lack of a smooth outline although his impression was that this represented fatty hyper-

TABLE 1

Patient No.	Age	Sex	Preoperative Diagnosis	Postoperative Diagnosis
1	51	F	Probable carcinoma of cecum	Lipoma of valve
2	49	F	Appendiceal abscess	Inflammation of cecum
3	38	F	Probable carcinoma of cecum	Non-specific inflammation
4	50	M	Possible carcinoma of cecum	Mucosal fold
5	47	F	Possible carcinoma	Diverticulum
6	46	F	Volvulus	Diverticulum
7	59	F	Probable carcinoma of cecum	Constriction ring



FIGURE 1

Case 1. Lipomatous infiltration of the ileo-cecal valve.

trophy of the valve. A right hemicolectomy was done, and the specimen showed a prominent ileocecal valve with the sub-mucosa of the valve replaced by a lipoma.

GROUP 2. INFLAMMATORY CONDITIONS

Case 2. This 49-year-old woman was admitted with what was thought to be an appendiceal abscess. She improved on antibiotics and was readmitted a month later for interval appendectomy. A barium



FIGURE 2

Case 2. Failure of the dilated cecum to fill with barium. There is a beak-like demarcation simulating a cecal volvulus.

enema was done and a smooth 2.5 cm. extrinsic indentation along the medial aspect of the cecum was noted, which was thought to be a peri-appendiceal mass (Figure 2). At surgery, a firm inflammatory mass was found in the posterior cecal wall, and the appendix could not be identified. The cecal mass was inspected and no malignancy was seen. An ileotransversostomy was done and the patient has been well since.

Case 3. This 38-year-old woman was admitted because of increased frequency of bowel movements, some of which contained blood clots. A barium enema revealed a constriction at the cecum that was thought to be a carcinoma (Figure 3). A right colectomy was done and the specimen showed a granular cecal mucosa with ulcerations near the ileocecal valve. The pointer shows one area of hemorrhage (Figure 4). Stains for tuberculosis and fungi were negative.



FIGURE 3

Case 3. Nonspecific inflammatory process simulating the picture of constricting carcinoma.

GROUP 3. ANATOMICAL AND CONGENITAL ABNORMALITIES

Case 4. The patient was a 50-year-old man with known diverticulosis and duodenal ulcer disease who was admitted because of left lower quadrant pain and melena. Ten months previously a barium enema showed diverticulosis in the left colon. A repeat enema revealed a vaguely outlined 1.5 cm. filling defect at the medial aspect of the cecal tip. A third barium enema, done the following week (Figure 5) showed the defect to persist. He was explored and a prominent mucosal fold was found in the tip of the cecum.



FIGURE 4

Case 3. Specimen after removal. The granular cecal mucosa is visible and the arrow indicates a small ulcer.

The appendix was removed and was normal, grossly and microscopically.

Case 5. This 47-year-old woman was admitted for cramping lower abdominal pain and distention. Previous surgery included a hysterectomy and an appendectomy. A barium enema showed diverticulosis of the entire colon and especially of the cecum, where spasm suggested an acute diverticulitis. At surgery a cecal mass was palpated and a right colectomy done. The specimen (Figures 6 and 7) showed marked thickening and inflammation in the area of the appendiceal stump, in the center of which was a diverticulum or cyst-like structure which measured 1 cm. in diameter. It could not be determined whether this was a true diverticulum or whether it was the stump of the appendix.



FIGURE 5

Case 4. A persistent filling defect in the medial aspect of the cecum simulates a polypoid mass.

Case 6. This 46-year-old woman was admitted for diarrhea and cramping lower abdominal pain. Previous operations included an appendectomy and hysterectomy. She was febrile and the white blood cell count was elevated. She was thought to have a volvulus and was explored. A cecal mass was found and a right colectomy done. A solitary diverticulum was found in the thickened cecal wall.

GROUP 4. PHYSIOLOGICAL DEFECTS

Case 7. This 59-year-old woman presented with a history of mild epigastric discomfort for three weeks. A complete workup including a barium enema was done, which showed what was thought to be a carcinoma of the ascending colon (Figure 8). Her appendix had been removed previously. She was explored, a colotomy was done and the only finding was an ileocecal valve which protruded approximately 1.5 cm. into the cecum. There was a constriction ring which accounted for the radiologist's impression of carcinoma.



FIGURE 6

Case 5. Inflammatory mass of the cecum, probably secondary to diverticulitis.

Discussion

Four of these seven patients were subjected to a right colectomy, either as a treatment of the benign condition or because of the probability of the lesion being malignant. None of these seven patients had lesions which could be diagnosed by sigmoidoscopy such as amebiasis. The patient with a constriction ring and the patient with a mucosal fold were easily diagnosed following colotomy, and were therefore spared more radical surgery. Repeated X-ray examinations are often helpful, and in one of our cases may have spared the patient a colotomy.

GROUP 1. BENIGN NEOPLASMS.

Case 1 illustrates the results of a lipoma of the ileocecal valve. Carcinoma was suspected and an unnecessary hemicolectomy was performed.



FIGURE 7

Case 5. Specimen after removal.

GROUP 2. INFLAMMATORY CONDITIONS (CASES 2 AND 3)

There are many instances of diffuse inflammatory lesions of the cecum in which no precipitating entity such as appendicitis or diverticulitis can be demonstrated. DeCamp and Penick,¹⁰ in 1955, reported 10 cases of acute non-specific inflammatory lesions of the cecum. He proposed that the cecum be opened and the diagnosis definitely established, and cultures taken. Then treatment was undertaken with specific antibiotic therapy. He reserved surgical treatment such as colectomy only in those cases thought necessary for the prevention or treatment of complications. He advised that colectomy should not be performed merely because a malignant neoplasm is suspected.

Case 3 in which the patient had ulcerations with hemorrhage near the ileocecal valve is similar to two cases presented by Shepard and Godwin in 1959.⁹ They related the hemorrhage to ileocecal prolapse. In our patient, however, these appeared to be primary cecal ulcerations with the site of hemorrhage as illustrated in Figure 7.

Inflammatory cecal masses are often indistinguishable from carcinoma at surgery and their proper treatment is debatable. A common cause for such masses may be solitary cecal diverticulum.³ This is a true diverticulum made up of all layers of the bowel wall. Leichtling⁴ stated that the incidence of cecal diverticulosis is 0.1 of 1 per cent of all cases of diverticulosis of the colon. Such diverticula have been imaginatively attributed to retention of the embryonic transient appendix⁵ before the true appendix develops. This seems improbable. Others⁶ feel a more common cause is right lower quadrant surgery of any type, but particularly the inverted appendiceal stump.

Mann,⁷ in reporting four of his own cases, has recommended that these diverticula be treated by sim-

ple excision if the inflammatory mass can be safely differentiated from carcinoma. As he points out, when the diverticulum is on the posterior or retro-peritoneal wall, treatment by this means is quite difficult. However, when the diverticulum is on the anterior wall such a procedure would be feasible. Updegrave⁸ has recommended that when the diverticulum is on the posterior wall that the cecum be opened and an attempt made to find the opening of the diverticulum. If such a diagnosis can be made more radical surgery can possibly be prevented.



FIGURE 8

Case 7. Physiological contraction ring simulating carcinoma in the proximal ascending colon.

GROUP 3. ANATOMICAL AND CONGENITAL ABNORMALITIES (CASES 4, 5 AND 6)

Only three years after the discovery of the X-ray, Cannon was studying the movements of the intestines after the administration of a bismuth subnitrate mixed with food. He was also the first to study the colon after the direct intra-rectal installation of a bismuth suspension.² Cannon's ring is the most common segment of contraction seen in the colon. This probably coincides with the junction of the primitive mid-gut and hind-gut, and may indicate an area in which the fibers of the superior and inferior nerve plexuses overlap. Other contraction ring areas less commonly seen are those of Busi and Hirsch. Despite knowledge of the existence of these areas, any constant filling defect must be considered due to an organic disease, and a colotomy may be ultimately required to diagnose their cause.

GROUP 4. PHYSIOLOGICAL DEFECTS (CASE 7)

Such cases are rare and difficult to diagnose. The presumptive hypertrophy of the ileocecal valve in

Case 7 seems to be a functional rather than an anatomical manifestation. There is no way of demonstrating this with certainty.

Summary

Cases of seven patients with benign lesions of the right colon are reviewed. Carcinoma of the cecum was the most frequent preoperative diagnosis.

Sigmoidoscopy to rule out amebiosis and repeated barium enemas to define the lesion are important means of avoiding unnecessary radical surgery.

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CONTROLLED SUBSTANCES ACT OF 1970

With the recent passage of the Comprehensive Drug Abuse Prevention Control Act of 1970, practitioners involved in handling controlled drugs will have a somewhat new and different responsibility. The Controlled Substance Act became active on May 1, 1971. As of that date the IRS and the Food and Drug Administration no longer issues a Registration Authorization to a person or firm to handle Controlled Substances. On May 1 registration must have been filed with the Bureau of Narcotics and Dangerous Drugs (BNDD). Future narcotic permits will be renewed at staggered intervals.

On or shortly after April 15, all persons and firms now registered with IRS (Narcotic Stamp Act) or FDA (DACA Drugs) received by mail a provisional registration application form. Along with the application were instructions for filling out the form. It was suggested that everyone review the instructions before filling out the provisional application form. Individuals now registered with the IRS and/or FDA received a new BNDD registration number in Block 5 of the application form. Beginning May 1 THIS NUMBER MUST be used on all correspondence to BNDD.

Individuals seeking registration for the first time after May 1 should request from BNDD, P. O. Box

28033, Washington, D. C., or from any BNDD Regional Office a Registration Application for New Registrants.

To insure uninterrupted medical care, all potential registrants who are legally qualified to register under the Controlled Substances Act and who have applied for BNDD registration, but have not yet received a BNDD registration number, may carry out the dictates of their profession without interruption. They may prescribe, dispense, distribute and conduct any such activity permitted by State Law by indicating instead of their BNDD number that "Federal registration applied for on (date)" Hospital residents and interns authorized to prescribe under State Law must use the hospital registration number in addition to the above statement.

The medical profession is expected to exercise caution and good judgment when prescribing controlled substances, and the policy on controlled substances does not relieve physicians from the responsibility to immediately apply for registration if they have not already done so.

After July 29, 1971, no activity with controlled substances will be permitted without use of a valid BNDD registration number.

*Diazepam appeared to be more effective
in the relief of anxiety-related
symptoms.*

Comparative Evaluation of Diazepam (Valium®)* and Phenobarbital

**For the Relief of Anxiety-Related Symptoms in Patients
Hospitalized for Acute Myocardial Infarction**

WILLIAM H. BENSON, JR., M.D.,† Marietta

ANXIETY AND RELATED emotional symptoms have been shown to result in physiologic changes associated with decreased efficiency of the heart,¹ or in decompensation when the cardiac reserve is low.² It has also been shown that patients with acute myocardial infarction suffer from significantly more emotional distress than those hospitalized for other illnesses³ and this could be related both to the precipitation of coronary occlusion and complications. Thus, the use of sedatives or tranquilizers is recommended for patients hospitalized for acute myocardial infarction to relieve apprehension, anxiety and related symptoms.⁴

For this reason, it was thought worthwhile to investigate the comparative usefulness of phenobarbital and diazepam in such patients. The effectiveness of diazepam in relieving anxiety and related symptoms is well established and the drug is considered quite safe.⁵

Methods and Materials

Twenty-nine patients (6 females, 23 males), aged from 39 to 78 years, hospitalized for acute myocardial infarction participated in the study. A double-blind randomized procedure was employed. Identically matched coded capsules containing either diazepam, 2 mg, or phenobarbital, 15 mg, were provided; 12 subjects received phenobarbital, and 17 diazepam. The dosage was one or two capsules three or four times per day. One patient in the phenobarbital group was dropped from the study after eight days because of increased agitation.

Clinical and Statistical Evaluation

The patients were observed and rated before treatment, daily during the first week of treatment, and at weekly intervals thereafter for up to three weeks. The symptoms rated included apprehension, restlessness, drowsiness, depressed mood, and preoccupation with illness. For purposes of statistical analysis, the symptoms' severity was rated on a scale from 0=none to 4=severe. Pre- and post-treatment ratings were compared at each evaluation period. The proportion (percentage) of patients who improved or worsened during treatment was determined, the calculation of which excluded patients at the best level of a given symptom (e.g., free of anxiety) or worst level of a given symptom (e.g., severely anxious) as such patients cannot improve or become worse, respectively. The difference between treatments was analyzed statistically by the chi-square test for 2×2 contingency table such as is described by Fisher.⁶ The average numerical score—pre- minus post-treatment values—was also calculated and compared between drug treatments by the *t*-test.

All patients received an oral anticoagulant, warfarin sodium (Panwarfin) and prothrombin times were determined at regular intervals. All appropriate cardiac medications, such as oral anticoagulants, digitalis, diuretics were continued at the discretion of the physician.

Results

Calculation of the proportion (percentage) of patients who improved indicated that diazepam was consistently superior to phenobarbital in decreasing the severity of apprehension, restlessness, depressed

* Roche Laboratories, Hoffmann-La Roche Inc., Nutley, New Jersey.

† From the Center for Interpersonal Study, Smyrna, Georgia.

TABLE 1

IMPROVEMENT IN ANXIETY SYMPTOMS WITH DIAZEPAM (N = 17) OR PHENOBARBITAL (N = 11)

Symptom	Evaluation Periods (Days)							
	2	3	4	5	6	7	14	21
Apprehension								
Diazepam	29(17)	53(17)	76(13)	77(13)	100*(13)	100*(13)	100(11)	100(7)
Phenobarbital	18(11)	36(11)	56(11)	56(5)	57(7)	57(7)	50(4)	100(4)
Restlessness								
Diazepam	41(17)	71(17)	71(13)	85(13)	100*(13)	100*(13)	100(11)	100(7)
Phenobarbital	36(11)	45(11)	45(11)	67(5)	57(7)	57(7)	75(4)	100(4)
Depressed mood								
Diazepam	25(17)	44(17)	63(13)	67(13)	92(13)	100*(13)	100(11)	100(7)
Phenobarbital	9(11)	36(11)	17(11)	44(5)	57(7)	57(7)	75(4)	75(4)
Preoccupation with illness								
Diazepam	29(17)	47(17)	59(13)	69*(13)	77(13)	92(13)	91(11)	100(7)
Phenobarbital	9(11)	18(11)	27(11)	22(5)	57(7)	57(7)	50(4)	50(4)

* $p < 0.05$ —one-sided comparison.

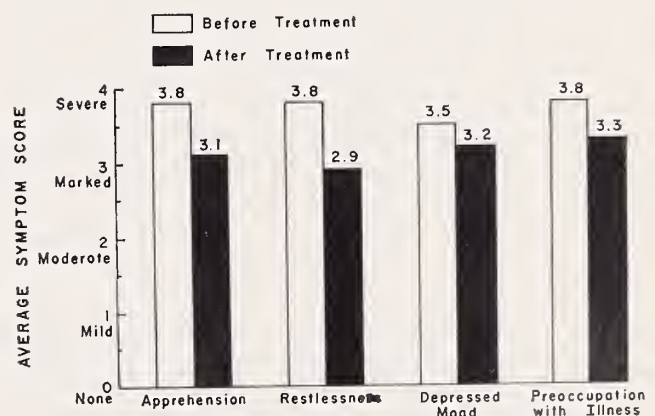
The numbers in parentheses indicate the number of patients evaluated.

mood, or preoccupation with illness (Table 1). The differences between treatments reach statistical significance at the 5th day for preoccupation with disease ($p < 0.05$), at the 6th and 7th days of evaluation for apprehension and restlessness ($p < 0.05$), and at the 7th day for depressed mood ($p < 0.05$). Diazepam also tended to maintain improvement in symptomatology more consistently than phenobarbital as shown by the fact that in the phenobarbital group apprehension increased in some patients, and depressed mood increased in about one-third of the subjects in the last two weeks of the observation period.

Statistically significant differences favoring diazepam over phenobarbital could also be demonstrated in calculated average improvement scores for apprehension ($p < 0.004$) depressed mood ($p < 0.005$), restlessness ($p < 0.004$) and preoccupation with illness ($p < 0.003$) (Figures 1 and 2).

The average daily dose of warfarin sodium was 7.4 mg in the diazepam group and 8.2 mg in the

Figure 2
IMPROVEMENT IN ANXIETY-RELATED SYMPTOMS IN PATIENTS RECEIVING PHENOBARBITAL (N=11)



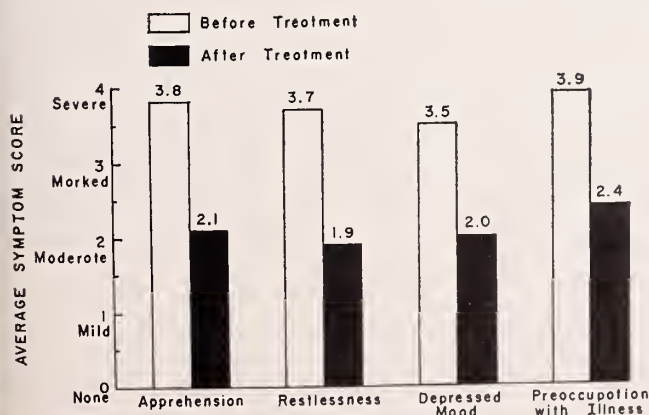
phenobarbital group; the respective average prothrombin time was 20.3 per cent and 19.9 per cent.

About one-third of the subjects in both groups initially complained of drowsiness and this increased as treatment progressed in from 22 to 29 per cent of the subjects in the phenobarbital group but not in the diazepam group. One subject in the phenobarbital group died following ventricular fibrillation.

Discussion and Conclusions

The results of the present study indicated that diazepam not only provided improvement of anxiety-related symptoms in a greater number of subjects hospitalized for myocardial infarction than phenobarbital, but that it also tended to maintain improvement more consistently as treatment continued. Statistically significant differences favoring diazepam over phenobarbital could be demonstrated in average (pre- minus post-treatment) improvement scores for apprehension, depressed mood, restlessness and preoccupation for the illness.

Figure 1
IMPROVEMENT IN ANXIETY-RELATED SYMPTOMS IN PATIENTS RECEIVING DIAZEPAM (N=17)



COMPARISON / Benson

Phenobarbital is known to decrease the plasma half-life of coumadin-type oral anticoagulants, usually requiring upward adjustment of the dosage when both drugs are used simultaneously.⁷ Diazepam does not affect the metabolism or dosage of coumadin-type anticoagulants.⁸ It is of some interest therefore that the average daily dose of warfarin in this study was somewhat larger in the phenobarbital group than in the diazepam group (8.2 vs 7.4 mg).

The importance of evaluating the psychologic as well as the organic status of patients with heart disease is well recognized,^{4, 9} and the use of sedatives or tranquilizers to relieve apprehension, anxiety and related symptoms is considered good medical practice.⁴

Patients with acute myocardial infarction find hospitalization a disturbing experience. The hospital environment may be instrumental in provoking potentially serious psychiatric disturbances.¹⁰ Anxiety is known to facilitate the development of untoward reactions to sensory deprivation in the monotonous environment,¹¹ which should be combated by the judicious use of sedative medication. Therefore, minor tranquilizers such as diazepam are to be preferred when daytime sedation is indicated. Barbiturates may frequently accentuate excitement and delirium in such patients.¹²

Summary

In a double-blind randomized study the comparative effectiveness of diazepam (Valium) and phenobarbital was evaluated for alleviating anxiety-related symptoms in 28 patients (6 females) hospitalized for acute myocardial infarction. The patients received either phenobarbital, 45 mg to 2 gm (12 subjects), or diazepam 6 to 16 mg per day (17 subjects). Symptoms were rated for severity from 0=none to 4=severe at various observation periods—daily for one week and weekly thereafter for a maximum of three weeks. Diazepam produced consistently greater improvement of apprehension, restlessness, depressed mood, or preoccupation with ill-

ness than phenobarbital and the differences reached statistical significance ($p < 0.05$) at several observation periods. Diazepam also tended to maintain improvement more consistently. Average (pre- and post-treatment) symptom severity scores calculated for apprehension, restlessness, depressed mood, and preoccupation for illness showed statistically significant differences in improvement ($p < 0.003-0.005$) favoring diazepam over phenobarbital.

It is concluded that because of its effectiveness and safety, the use of diazepam is preferable to phenobarbital for relieving anxiety-related symptoms in patients hospitalized for acute myocardial infarction.

Route 4 30060

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This well established procedure has become a useful adjunct to the rehabilitation of the rheumatoid arthritic patient.

Metacarpal Phalangeal Joint Replacement by Silastic Implants in Rheumatoid Arthritis

DAVID F. APPLE, JR., M.D., *Atlanta*

RHEUMATOID ARTHRITIS frequently produces severe hand deformity characterized by ulnar drift, metacarpal phalangeal subluxation, or dislocation, and loss of function. Treatment of this type of hand has challenged the skilled surgeon for many years. Resection of the metacarpal phalangeal head was the original reconstructive approach described by Kestler³ in 1946, and later described in a slightly different form by Steindler.⁷ Fowler⁶ and Vaino⁹ advocated relocation of the extensor mechanism, and release of contracted intrinsic muscles was introduced by Littler.⁴ All of these procedures have become basic surgical considerations in correcting these usual deformities. In reviewing results of surgery on these deformed hands, Flatt² noted recurrence of the subluxation and felt that a metallic prosthesis to replace the joint might prevent recurring deformity. Swanson⁸ developed a prosthesis utilizing silicone rubber, and Niebauer⁵ designed a flexible hinge dacron prosthesis.

Materials

In 1967, the Arthritis Service of Rancho Los Amigos Hospital in Downey, California, in cooperation with Dr. A. B. Swanson and his multi-centered field trial studies, began using silicone rubber prostheses in reconstruction of severely deformed rheumatoid hands. A two-year experience using this prosthesis is documented in the following report. From September, 1967, to December, 1969, 30 patients representing 40 operative hands, had Swanson-type prostheses inserted in 160 metacarpal phalangeal joints. The goal was to improve hand function.

Method

Each patient was carefully evaluated preoperatively. The criteria for metacarpal phalangeal arthroplasty were:

1. Subluxation (volar or ulnar drift) or dislocation of the metacarpal joint.
2. Evidence of joint erosion and destruction with intramedullary integrity on roentgen examination.
3. Intact tendon control.
4. Pain. However, surgery was not denied if pain was not a factor.
5. Cooperative patient attitude.

Range of motion and deformity was checked for:

1. Ulnar deviation.
2. Metacarpal phalangeal flexion and extension, both active and passive.
3. Interphalangeal flexion and extension, active and passive.

Grasp strength as well as palmar pinch strength was measured.

Using a test described by Carroll,¹ the upper extremity function was evaluated on each patient.

Postoperative evaluations were made at eight weeks, six months, one year and two years.

Operative Technique

The operative procedure used was that as described by Swanson. Care in releasing the contracted



Characteristic rheumatoid hands showing ulnar drift and dislocation of the metacarpal phalangeal joints.

soft tissue elements and repositioning of the dislocated extensor tendon with careful capsular repair was followed in all hands.

Postoperative Management

On the fifth day the initial dressing was removed and a volar resting splint was made with the metacarpal phalangeal joints in slight flexion, maintaining good grasp position. If the proximal interphalangeal joints had good motion preoperatively, the metacarpal phalangeal joints were placed in extension. Stiff proximal interphalangeal joints require more metacarpal phalangeal flexion. At all times gross grasp was not compromised. A dorsal splint with an extension assist outrigger attached was used if needed. Initially, the extremity was splinted for 24 hours with the fingers individually ranged several times during the day. The patient was encouraged to do this actively after the first week of splinting.

Two weeks after surgery the patient discontinued the daytime splint and was allowed to use the operative hand as an assist in light activities. Activities which position the fingers in ulnar strain were discouraged and substitute activities were taught. If more flexion was desired, a "knuckle-bender" was instituted. To insure metacarpal phalangeal flexion range in patients with good interphalangeal motion, splints to block proximal interphalangeal flexion were encouraged for use part of the day. The sutures were removed in 18-21 days.



Silastic prosthesis.

Results

Forty hands in 30 patients were reconstructed using 160 silastic prostheses. Two patients representing eight prostheses died without adequate follow-up, so that 38 hands (152 prostheses) were included for analysis.

The average duration of the disease was 13.7 years in women and 8.1 years in men.



Silastic prosthesis placed in the index metacarpal phalangeal joint.

The following is documented for evaluation:

	Hands	Prostheses
a. 8 week testing	38	152
b. 6 month testing	25	100
c. 1 year testing	20	80
d. 2 year testing	11	44

Motion

Silastic arthroplasty of metacarpal joints did increase joint motion. More important than the amount of motion increase obtained was the position in which this gain occurred; it was the repositioning of motion that resulted in increased function. Range of motion of the interphalangeal joint, an integral part of the functional unit affects the metacarpal phalangeal joint. Proximal interphalangeal joint motion increased in 85 per cent of the patients followed for two years; motion gradually increasing from one examining period to another.

Stiff preoperative proximal interphalangeal joints should create the necessity for increased metacarpal phalangeal joint range postoperatively. This was the case, as 74 per cent showed an increase of more than 30 degrees in the postoperative metacarpal phalangeal joint range. Contrarily, with more supple proximal interphalangeal joints, only 52 per cent experienced a similar increase in range of the metacarpal phalangeal joint.

TABLE I
JOINT MOTION INCREASE

	6 Months		2 Years	
	MCP	PIP	MCP	PIP
	Per	Per	Per	Per
	Cent	Cent	Cent	Cent
Motion Increase	68	54	66	85
Motion Same	4	13	7	
Motion Decrease	28	33	25	15

Deformity

1. **ULNAR DRIFT**—The inability to actively correct ulnar drift of the little finger was chosen to evaluate this deformity. Preoperative ulnar drift ranged from 0-90 degrees. At the two year evaluation, all 11 patients demonstrated improvement averaging 57 degrees of correction.

2. **METACARPAL PHALANGEAL FLEXION DEFORMITY**—Active metacarpal phalangeal extension of each finger was measured and the average for the hand (four digits) obtained. Preoperatively, 20 hands had a metacarpal phalangeal joint flexion deformity of more than 60 degrees. Postoperatively, 22 hands had less than 20 degrees of deformity.

Upper extremity function was tested using Carroll's method. Ninety-nine is normal for the dominant hand and 96 for the nondominant hand. Improvement more than 10 points was recorded as an increase. Eighty-four per cent increased hand function at eight weeks, only one patient decreased function. One individual increased 56 points. At two year postoperative, 60 per cent had increased function, and again only one patient lost function.

Hand function alone was also tested. The most points possible was 52. An increase of five points was considered an improvement. At the eight week test period, 86 per cent of the patients had improved while 10 per cent lost function. Thirty-three points was the maximum recorded improvement. Two years postoperative, 70 per cent had improved and only one patient (10 per cent) lost function. Thirty-five points was the maximum improvement. The one patient who obtained a perfect score at eight weeks, maintained it two years later.

TABLE II
FUNCTION

	Increase Per Cent	Same Per Cent	Decrease Per Cent
Upper Extremity	60	31	9
Hand Alone	70	20	10

Complications

Seven prostheses of 160 (4 per cent) have fractured, but have not been removed. One prosthesis was removed because of chronic infection.

Discussion

Reconstructive procedures of the metacarpal phalangeal joint evaluated regarding hand function, if effective, should:

1. correct deformity
 2. increase motion
 3. provide stability
- and each anticipated requirement appreciated.

Deformity

Two plane metacarpal phalangeal joint deformity consisting of proximal phalanx volar subluxation and ulnar deviation may be an early finding, and correction may improve only cosmesis. However, correction of metacarpal phalangeal flexion deformity proved to be the basis for increasing function by placing the increased joint motion in a better functional range. It should be noted that sudden changes in flexion deformity in the postoperative period may indicate prosthesis fracture.

Motion

Metacarpal phalangeal joint motion was improved by silastic arthroplasty, and the average increase was 25 degrees. The nonoperative proximal interphalangeal joints stand a better chance of increased motion due probably to combined effects of skeletal shortening, intrinsic release and metacarpal phalangeal stability.

Stability

The silicone rubber implant acts as a reliable spacer preventing recurrence of ulnar deviation, metacarpal phalangeal telescoping and dislocation. Stability forms the structural framework for improved function.

Conclusions

Silastic arthroplasty of the metacarpal phalangeal joint in rheumatoid hands decreases deformity and pain, increases motion and improves cosmesis and function, and is, therefore, worth consideration in reconstructive surgery of the rheumatoid hand.

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Congressional Considerations of Medicare and Medicaid

SENATOR HERMAN E. TALMADGE, *Washington, D.C.*

IT IS A GREAT PLEASURE for me to visit with friends who are doing so much to improve health care for Georgians. Health care—a subject of intimate concern to all of our citizens—is a matter with which I have become increasingly involved because of my service on the Finance Committee which has legislative responsibilities for the major government health programs, Medicare and Medicaid.

During the past two years the Finance Committee devoted a great deal of time to review and restructuring of Medicare and Medicaid. Our concern was three-fold: program costs, quality of care, and excessive red tape.

The entire Congress is greatly concerned about the costs of the Medicare and Medicaid programs. The programs are in serious financial trouble, and they are adversely affecting health care costs and financing for the general population.

The Part A Hospital Insurance Trust Fund has a projected deficit, above the original estimates, over a 25-year period of anywhere from \$216 billion to \$370 billion dollars, depending on which estimate of hospital cost increases is used.

The Part B portion of Medicare which pays doctors' bills was originally financed through a monthly premium charge to the elderly of \$3 a month, and an equal contribution from the general revenues of the Federal Treasury. This Part B premium has nearly doubled during the past five years. Each premium increase has been matched by a corresponding increase in Federal general revenue expenditures.

Cost Increases

Cost increases in Medicaid are equally staggering. In fiscal 1970, with all but two states participating in the program, the Federal share amounted to \$2.5 billion. Including intermediate care, the estimated cost of Federal Medicaid funding for fiscal year 1971 is \$3.5 billion and for fiscal 1972 is \$4.2 billion. Counting state and local funding, the total

estimated expenditure for Medicaid in fiscal 1972 is \$7.2 billion.

These figures speak for themselves. Responsible legislators must be concerned about cost increases such as these.

The inflationary spiral of medical care prices confronts the working man with increased social security taxes to pay for Medicare, increased state and local taxes to pay for Medicaid, more of his Federal tax dollar going to the Federal share of these programs, and increases in his private health insurance premiums.

As government is forced to pay more and more to keep up with inflation in the costs of health services, less and less is left for better services, improvements in benefits, or coverage of additional groups. The government health dollar is being eaten away by the costs of Medicare and Medicaid.

Quality of Care

Also of great importance is the quality of care being provided under these programs. Doctors have frankly called our attention to excessive and medically unnecessary services being ordered by physicians fearful of malpractice liability.

Other situations of duplicative and overlapping services by physicians and hospitals were extensively described to and documented by the Committee.

We were told of patients commonly remaining hospitalized beyond their need—when lower-cost extended care or home care would be more appropriate. And it just makes sense that if some patients are getting more care than they need, others are going to get less. Our health care delivery system is subject to enough demands already that it should not have to bear the additional burden of duplicative, excessive, or unnecessary services.

My remarks will focus on three rather specific issues. Two of these are issues on which the Committee spent a great deal of time: peer review and the "Bennett Amendment," and Health Maintenance

Organizations. The third issue concerns future health insurance legislation.

Bennett Amendment

The Bennett Amendment has been the subject of considerable interest among people in the health care field across the United States. It was originally introduced by Senator Wallace Bennett of Utah, a distinguished and dedicated member of the Finance Committee. His purpose was to insure proper utilization and quality control of Medicare and Medicaid services through continuing and comprehensive medical evaluation.

I doubt that anyone can find fault with this objective. Yet, the Bennett amendment—which operates on the principle that doctors review doctors—triggered hot debates in medical and health care circles all around the country.

As a result of this, healthy discussion attitudes, criticisms, and suggestions flowed into the Committee. In large measure it can be said that the peer review amendment the Committee on Finance approved and which the Senate passed reflects the persuasion and the participation not only of a majority of legislators but also reflects the constructive efforts of concerned health care practitioners and hospitals.

Background on PSRO

Let me describe the background from which the Committee amendments on PSRO emerged. During the course of the Finance Committee's intensive review of the health programs, it became increasingly obvious that some new organized mechanism had to be developed to assure proper utilization and quality control.

The Committee was convinced that, in general, existing utilization review activities simply are not adequate. Present review is fragmented, retrospective, and incomplete. Numerous witnesses testified that a significant number of the health services provided under Medicare and Medicaid were in excess of those which would be found medically necessary.

In view of the high cost of hospital and nursing home care, and the costs of medical and surgical procedures, the economic impact of this over-utilization becomes extremely significant. The Committee was also concerned about the effect of overutilization on the health of the aged. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.

Recognizing this general consensus regarding the ineffectiveness of utilization review, the Department of Health, Education, and Welfare submitted, and the House of Representatives approved, a provision to

build a mechanism for utilization and quality control within the government. Under that provision the Secretary of HEW would appoint program review teams in each state to review services.

Placing Responsibility

In the Finance Committee we were convinced that the government and its agents did not have the capacity to effectively audit the health services provided under federal programs. Aside from the question of whether the government *could* effectively audit the need for and the quality of medical services, many of us had serious reservations as to whether the government *should* perform these functions. Many of us felt that the key to making the Medicare system workable and acceptable was the physician.

In line with these feelings, we saw merit in placing review responsibilities with those best able to decide whether care was necessary and of proper quality—the practicing physicians themselves—as opposed to placing such responsibilities with a government agency.

During our deliberation in executive session on the Bennett amendment, we reviewed the pertinent testimony from a wide variety of witnesses, and in light of that testimony we made some significant modifications in developing the Committee amendment on Professional Standards Review.

One of the major modifications related to a concern expressed by nearly every hospital organization that the amendment as originally drafted might weaken present hospital quality and utilization controls where they are effective and are doing a good job.

The Committee took note of this argument and authorized local review organizations to accept the results of in-house hospital review activities where they found such review activities to be effective.

Hospital organizations also expressed sharp dissatisfaction that under the original provision every non-emergency hospital admission would require prior approval from the review organization. Again the Committee found a reasonable solution by allowing the PSRO to limit prior approval requirements to those diagnoses or institutions or practitioners where they felt it would be necessary to adequately control utilization.

Thus, if the PSRO is satisfied that a given hospital is doing a good job of screening out unnecessary admissions then it would not superimpose its judgment on top of the hospital. The amendment also provides that only physicians with active hospital staff privileges would review hospital care, thus avoiding the possibility of review by those who might be unfamiliar with hospital practice.

CONSIDERATIONS / Talmadge

Major Goals

Through all of our deliberations, our major premises and goals were very clear. We knew that some kind of review mechanism must be developed. We felt very strongly that only physicians could and should review the quality of medical care and the necessity for such care. We felt that the present situation—where insurance company clerks often question medical determinations and judgments before approving claims for payment—was an affront to responsible members of the medical profession.

Finally, it was clear that the major alternative to peer review was expanded control of medical practice by government agencies and insurance companies. That seemed to be an undesirable alternative.

It is gratifying that numerous organizations and individuals who had expressed reservations concerning the PSRO provision as originally introduced, have carefully studied the modified Committee provision and now express their support.

I am particularly gratified that here in Georgia, our physicians, through the Medical Association of Georgia, support the provision, and express an eagerness to demonstrate that the government need not move in to control medical practice wherever it finances such practice.

By this single amendment the Senate acted to do something about health care costs, quality of care and red tape. By obtaining advance approval of medical necessity for certain hospital admissions and medical procedures, unnecessary services will not be paid for, but equally important, patients, physicians, and hospitals alike will know usually before services are rendered whether Medicare will pay for them.

By reviewing hospital stays under a system related to the patient's age and diagnosis rather than an arbitrary term of days as is done presently, unnecessary care can be kept to a minimum.

And finally by placing responsibility for determining medical necessity on physicians, the PSRO amendment will facilitate payment of claims by carriers and intermediaries and reduce bureaucratic red tape in the settlement process.

Health Maintenance Organizations

Another focus of a great deal of attention last year was the President's proposal to stimulate so-called "Health Maintenance Organizations" as a means of delivering comprehensive health services to Medicare beneficiaries. Discussion of Health

Maintenance Organizations is unfortunately handicapped by the fact that the Administration has never been very specific in defining a "Health Maintenance Organization" except in terms of the kind of prepaid group programs such as the Kaiser Foundation on the West Coast.

Under Medicare the beneficiary is free to choose how he wishes to receive his medical care, whether from a private practitioner on a fee-for-service basis or from a prepaid group practice plan.

The Administration argued last year that prepaid group practice was a more efficient and economical way to deliver medical care. While it is true that a number of large prepaid group practice plans apparently do provide quality medical care in an efficient fashion, the Administration position is too sweeping and subject to serious question.

Prepayment Problems

Paying organizations on a prepaid, capitation basis to provide medical care raises a number of problems. Let me describe two of the problems which the Finance Committee recognized.

The first involves how much to pay such an organization in advance. The Administration advocated paying 95 per cent of the current per capita costs of providing Medicare benefits in an area, and claimed that this would automatically result in a 5 per cent savings to the government.

Unfortunately, it is not that simple. The organization may be serving members who, compared to the average Medicare population, are both younger and healthier. In this case, paying 95 per cent of average per capita costs for these people could result in higher program costs overall. So in reality, a series of complex actuarial adjustments would have to be made to determine payment rates. We added a provision requiring such adjustments.

A second problem involves quality control. It may well make sense to argue that prepayment rewards efficiency within the health care system, while fee-for-service payment rewards inefficiency. Yet, the converse is also true—fee-for-service payment encourages doctors to render all care necessary, whereas prepayment, by itself, may reward those who cut costs by not providing necessary services.

Therefore, if the government is to prepay for health care, it has an obligation to monitor the quality and availability of that care to beneficiaries very closely, particularly in dealing with older people who may not be in a good position to judge the adequacy of their care. Again we changed the provision to provide for review of the quality of care—particularly by the PSRO's.

These were just two major problems which the Finance Committee dealt with as we considered the

Health Maintenance Organization provision—to assure that payments would be equitable and that services would be adequate. To provide some benefit to the elderly patient from potential efficiencies and to avoid excessive profits, the Committee stipulated that “profits” or retention above the organization’s regular retention must be used for increased benefits.

Additionally, the Committee established a minimum size of 10,000 enrollees to be enrolled within three years for Health Maintenance Organizations. This would guard against small organizations which might not really have adequate capacity to provide all necessary services. Nonetheless, despite the Committee’s improvements, I still had misgivings about the HMO concept and did not support it in Committee. But even here as I have described them, the Finance Committee amendments concerned themselves with cost controls, quality of care and easing of administrative red tape.

Health Care Legislation

Now as to the situation with respect to health care legislation this year, the outlook seems pretty clear. Both the Ways and Means Committee and the Finance Committee devoted a great deal of time last year to amendments designed to improve Medicare and Medicaid. I have discussed some of the results of those efforts. However, due to a legislative log jam which developed at the end of the last session of Congress, the Medicare and Medicaid changes approved by the Senate and the House did not become law.

So, over the next few months, the Congress will continue the process of agreeing upon and enacting amendments to Medicare and Medicaid. Since both Ways and Means and Finance were in fairly close agreement on these amendments last year, I would anticipate early passage—barring the possibility of delay caused by questions relating to welfare reform.

Passage of legislation is just part of the ballgame. There is always concern as to whether legislation will be promptly and effectively implemented by administrators at Federal, State and local levels in accordance with the intent of Congress.

Legislative Speculation

Now we leave the area of legislative probability and get into speculative areas. All of you are aware of the increasing focus being placed on health legislation. President Nixon listed a Family Health Insurance Program as one of six major goals in his State of the Union address. At the same time, a substantial number of organizations, legislators, and citizens are calling for enactment of some type of

National Health Insurance legislation, and bills have been or will be introduced which reflect the viewpoints of such diverse organizations as the American Medical Association, the AFL-CIO, the American Hospital Association and the Health Insurance Industry.

There is a great variation between these national health proposals. Some call for a minimal federal role, with the government granting tax credits for the purchase of private insurance packages. Other proposals call for complete federal financing of health care through federal revenues and payroll taxes, with a vastly enlarged federal role in controlling the delivery of health care.

The various plans involve first-year costs ranging from about \$2.5 billion a year for basic catastrophic coverage to \$46 billion for a full-dress national health plan. President Nixon proposes a Family Health Insurance Plan or FHIP which is intended to substantially replace Medicaid through government purchase of a basic health insurance policy for all of the poor with the medically indigent contributing a share toward the cost of the premium to the extent of their ability. That proposal will receive careful attention, but while almost everybody agrees that the Medicaid program has had many difficulties, we would not want to substitute a new and possibly greater set of problems.

Examine Proposals

As we learned last year with the President’s Welfare Expansion Plan, talking about reforming or replacing a program is not the same thing as offering legislation to actually accomplish what the easy rhetoric claims. As Congress examines the FHIP proposal, we will be looking at a number of things, including:

- the extent to which cost controls, such as those we are finally instituting in Medicare and Medicaid, are built into the proposal, and

- the extent to which the proposal would supplant Medicaid in areas such as skilled nursing home care.

Congress is interested in reform of Medicaid, but Congress will be looking for more than rhetoric. If we legislated solely on the basis of the claims of sponsors, the nation would be bankrupt.

Another item likely to receive attention is Catastrophic Health Insurance. Senator Russell Long, Chairman of the Finance Committee, introduced such a proposal last year which was passed in the Finance Committee by a vote of 13-2. The amendment was voluntarily laid aside in the adjournment squeeze at the end of the Congressional session.

Catastrophic Insurance

Many of us in the Senate—just as I am sure you

are—are concerned about the often devastating effect which a catastrophic illness can have on families unfortunate enough to be affected by such misfortune. It seems to me that government should respond to this very real problem in responsible, careful fashion and without charging blindly ahead. Medicine and science are now often able to mitigate the physical effects of a catastrophic illness or injury, and our government, through appropriate means, should act to mitigate the financial effects of such a catastrophe. Consequently, I anticipate supporting a Catastrophic Health Insurance Plan again this year and expect that legislation along those lines would be sympathetically considered by the entire Congress.

Predictions on the legislative course of broad National Health Insurance proposals would be difficult to make at this time. My personal feeling, which

I think is shared by many members of the Congress, is that until we have developed and employ adequate professional controls on costs and services in the health care field and effective public and private administrative capacity, National Health Insurance might become a fiscal nightmare which would haunt the sponsors and the nation for many years to come. The stakes are too high for us to be swept away with good intentions.

However, as we gain experience with Medicare and Medicaid, and as we see the effect of some of the improvements we expect to make this year, a gradual and orderly expansion of health insurance programs might come about.

When that time does come, I am certain that the Congress acting on the legislation will be challenged by the same considerations—cost controls, quality of care and the problems of administration (red tape)—facing us in Congress today.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL JULY 18, 1971

Discussion of Separation of Department of Health into Two Departments: Heard discussion regarding the possible separation of the Division of Mental Health from the Department of Health from Mr. John Moore, MAG Attorney, Dr. Lamar Peacock, member of the Board of Health, and Dr. A. S. Yochem, Chairman of the MAG Committee on Mental Health. A detailed report will be made at the September Council meeting.

Internal Revenue Service Ruling on Taxable Income from Medical Journal Advertising: Received for information the fact that the IRS has assessed the Association for the years 1968 and 1969 on income from *Journal* advertising. Deferred action until the next Council meeting.

Appointments: (1) Committee on Private Practice; (2) Fourth District Board of Health nominations; (3) GRMP; (4) Advisory Committee to Board of Examiners of Practical Nurses nominations; (5) Advisory Committee to Medical College of Georgia Study on Continuing Education for Nurses.

Committee on Peer Review Request: Reconfirmed previous action assigning authority for initial claims review to the Foundation with the Committee on Peer

Review serving as the appeal policy-making board.

Foundation: Reconfirmed the method of selection of the Georgia Medical Care Foundation Board of Directors.

Utilization Review Demonstration Project: Voted approval of the MAG's application for a grant to study hospital and ECF utilization review in a selected five-county area.

1971 House Actions: Approved a Staff Report on Field Service including the employment of a second Field Representative.

Law Suit Against Construction Company and MAG: Received for information the fact that the law suit against MAG and other defendants in the death of a construction worker had been settled with the Association not being held liable in any way.

Legality of Physicians' Assistants: Requested a report from Legal Counsel on the present legality of physicians' assistants.

Future Meeting Date: Executive Committee meeting scheduled for August 8, 1:00 p.m., Georgia Suite, Sheraton-Biltmore Hotel, Atlanta, at conclusion of Committee Conclave.

*This study made evident the necessity
for more systematic information about
community mental health in Georgia.*

Mental Health Problems in Georgia: A Selective View*

CHARLES W. TUCKER, Ph.D., *Atlanta*

AN IMPORTANT ASPECT of community mental health is prevention. Prevention requires that we are aware of the problems that require solutions. At times it is simply a matter of selecting from an extensive collection of recurring problems and applying the available skills toward their solution. More often it is a matter of discovering and formulating the problems so that the available skills can be applied toward their solution. This report deals with the latter issue as it is relevant to community mental health.

In the Spring of 1969 the Department of Psychiatry together with the Division of Mental Health of the Georgia Department of Public Health and the Georgia Mental Health Institute decided to obtain information regarding the mental health problems in Georgia. This information was necessary for planning the future activities of the Continuing Education Community Mental Health Grant (MH-11034-01) held by the Department of Psychiatry. To obtain this information we conducted a survey using mailed questionnaires. The purpose of the survey was to discover: (1) the nature of the mental health problems in Georgia, (2) the degree of local support for mental health programs and (3) the groups who were most active in community mental health programs. This is a report of that survey.

Procedures

During the months of May and June of 1969 the Director of the Community Service Branch, Division of Mental Health, Dr. Ilhan Ermutlu assisted by Mr. Derril Gay mailed questionnaires to each county in Georgia. These questionnaires were to be completed by the District Directors of Public Health,

District Directors of Public Health Nurses, Executive Directors of the Mental Health Program or Public Health Nurses. With each questionnaire was a letter from Dr. Ilhan Ermutlu and instructions written by Dr. Charles W. Tucker. A stamped envelope addressed to Dr. Tucker was enclosed for returning the questionnaire.

The questionnaire contained several questions about mental health. To obtain a list of mental health problems the following question was asked:

List the four most serious mental health problems that you have in your community and/or district beginning with the most serious to the least serious. If you have no problems check here

The respondent was allowed four lines to write an answer to this question. This type of open-ended question was used instead of a check-list type to avoid suggesting to the respondent certain types of mental health problems. Although this type of question is more difficult to analyze, it avoids the difficulty of biasing the respondent and suggesting problems that were not previously evident to the respondent.

Next, to obtain an estimate of local support for mental health in the community we asked the following question:

To what degree does the local community support efforts in mental health? (check one)
Very high .. High .. Neutral .. Low .. Very low

Following this we asked:

How many voluntary associations and/or groups are currently involved in projects in the area of community mental health?
.....(number) out of(total number).

Then we asked these questions:

What voluntary association and/or group is *most* involved in community mental health?

Name of Group
Leader of Group = x

* This study was supported, in part, by the Continuing Education Grant-Community Mental Health Grant (MH-11034-01). Dr. Ilhan Ermutlu, Director, Community Service Branch, Division of Mental Health and Mr. Derril Gay assisted in this study by mailing the questionnaires. Assistance in coding was given by Sondra W. Tucker and Dr. Gary Albrecht commented on the initial draft. Several interpretations of the data were discussed with Dr. Harold M. Chandler who made an extensive critical analysis of the initial draft. The final interpretations of the data were the sole responsibility of this author and do not represent the views of any other agency, organization or person.

What voluntary association and/or group is *least* involved in community mental health?

Name of Group
Leader of Group

These latter three questions were designed to obtain some measure of actual support for mental health in each community as well as some indication of the respondents' knowledge of these issues. The remainder of the questionnaire contained questions about the Continuing Education Project as well as questions asking for the respondent's name, occupational title, address and telephone number. The data from the questions regarding the Continuing Education Projects are not included in this report.

Data Analysis

This section describes the procedures and rationale for the categories used in coding the question regarding the identifications of mental health problems and voluntary associations and/or groups. First the procedures for coding the types of mental health problems are described followed by the procedures used to code the information about the support groups.

To construct the categories for the mental health problems we employed typical content analysis procedures. First, a list of mental health problems was taken from a random sample of questionnaires. Next, the list was categorized by similarity of problems. Finally, the remainder of the questionnaires were coded using this list. It was found that the categories constructed from the sample were adequate to code all the problems mentioned by the respondents.

The categories are sufficiently broad but meaningful. First, there was a group of problems which described certain needs indicating a lack of community resources. These could be coded into the lack of: trained personnel, community interest, facilities and funds. Examples of those statements which were categorized in the Lack of Trained Personnel category are: "No doctor residing in county," "lack of sufficient psychiatrists in the area," and "shortage of staff." When statements such as: "lack of dynamic involvement of local citizenry," "lack of mental health education for general public," or "lack of local interest and participation" were written they categorized as: Lack of Community Interest. The other two categories: Lack of Facilities and Lack of Funds were only used for statements which specifically mentioned these needs.

There were statements which mentioned the lack of pre-patient care and post-patient care. When the statement: "not much attention to prevention" occurred it was categorized as Pre-Patient Care. Statements like "lack of after-care clinics," "lack of care for furlough patients from Central State" or "no concern for training former Central State patient" were placed in the Post-Patient Care category.

Finally, there was a set of statements which mentioned specific mental disorders, diagnoses or behavioral problems. These were categorized into two categories: Alcoholism and General Deviancy. The first category was only used when alcoholism was specifically mentioned while the other category includes a variety of labels for deviancy, ranging from "mental retardation" to "psychotics" and "schizophrenia." But because of this variety it was not deemed necessary or possible to make separate categories for each type. The majority of these statements, although less than the percentage of statements about alcoholism, referred to "mental retardation" or "emotional disturbances." None of the types of General Deviancy exceeded the percentage of statements mentioning alcoholism.

To analyze the information regarding the voluntary association we used several procedures. First, a percentage of group involvement was computed for the question asking about the number of associations involved. Second, a list of the groups was constructed from the answers to the questions about the names of the groups *most* or *least* involved in community mental health projects. Finally, this information was coded by specific names of association and/or groups.

Results

Of the 160 questionnaires mailed by the Community Services Branch only 56 per cent or 90 were returned. This number represents 50 per cent of the counties in Georgia but 80 per cent (24 of 30) of the returns were from counties containing mental health programs. Thus, although not a random sample, the returns are substantial enough to draw some conclusions about the state and quite adequate for drawing conclusions about mental health programs in Georgia.

Table 1 shows the composition of the sample by professional title and sex. This table shows that the majority of the respondents (77 per cent) were females while almost half of the sample were Public Health Nurses. There were two Psychiatrists, nine Directors of Public Health and 16 Directors of Mental Health Programs. Thus, the sample is weighed in terms of females and Public Health Nurses but this reflects the mental health programs in the state.

TABLE 1
COMPOSITION OF SAMPLE BY PROFESSIONAL TITLE AND SEX (JUNE-JULY, 1969; N = 90)

Professional Title	Sex		Total
	Males	Females	
Psychiatrist	2	0	2
Director of Public Health	7	2	9
Director of Mental Health Program	12	4	16
President Mental Health Association	0	2	2
Director Public Health Nurses	0	9	9
Public Health Nurse I and II ..	0	44	44
Staff Nurse	0	3	3
No answer	0	5	5
Total Number	21	69	90

The percentage for the different mental health problems are found in Table 2. The percentages for the various degrees of seriousness are computed separately. This table shows that the most serious category of problems is General Deviancy (26 per cent) with the next being the Lack of Facilities (19 per cent). Following these categories is Alcoholism (12 per cent), Lack of Personnel (11 per cent), Lack of Community Interest (11 per cent) and Lack of Post-Patient Care (10 per cent). Looking at the pattern of results we find that General Deviancy maintains the highest percentage throughout the degrees of seriousness while the Lack of Personnel is ranked second (14 per cent). Lack of Facilities, Lack of Post-Patient Care and Alcoholism are mentioned equally (11 per cent) with Lack of Community Interest close behind (9 per cent). In sum, this table shows that the major mental health problems mentioned by these mental health professionals are: General Deviancy, Lack of Personnel, Lack of Facilities, Lack of Post-Patient Care, Alcoholism and Lack of Community Interest.

TABLE 2
PER CENT OF MENTAL HEALTH PROBLEMS IN GEORGIA BY SERIOUSNESS IN JUNE-JULY, 1969

Type of Mental Health Problem	(N = 90)				
	Degree of Seriousness				Total
	First	Second	Third	Fourth	
Lack of personnel ..	11	28	7	9	14
Lack of community interest	11	11	9	8	9
Lack of facilities	19	17	8	1	11
Lack of funds	1	2	0	2	1
Pre-patient care	2	0	4	4	2
Alcoholism	12	11	11	8	11
General deviancy ...	26	24	28	23	25
Post-patient care ...	10	13	12	10	11
No answer	8	12	21	35	19
Total Per Cent ..	100	100	100	100	100
Total Number ...	(90)	(90)	(90)	(90)	(90)

Due to the large number of Public Health Nurses in this sample we decided to compare them with the other professionals regarding the most serious mental health problem. The results in Table 3 show a number of similarities and differences. For example, the Public Health Nurses and the Other Professionals agree that the Lack of Personnel and Facilities are problems similar in seriousness. The Other Professionals mentioned Lack of Community Interest and General Deviancy more than twice as often as the Public Health Nurses. The Public Health Nurses, on the other hand, mentioned Alcoholism and Post-Patient Care more than twice as often as the Other Professionals. Thus, it appears that the Other Professionals view the more general problems as the most serious while the Public Health Nurses view problems which deal with mental health care or treatment as most serious. One can only speculate on the reasons for these apparent differences.

TABLE 3
A COMPARISON OF PUBLIC HEALTH NURSES AND OTHER PROFESSIONALS REGARDING THE MOST SERIOUS MENTAL HEALTH PROBLEMS (JUNE-JULY, 1969; N = 90)

Type of Mental Health Problem	Public Health Nurse Per Cent	Other Professionals Per Cent	Total Per Cent
Lack of personnel	11	11	11
Lack of community interest	7	15	11
Lack of facilities	16	20	19
Lack of funds	2	0	1
Pre-patient care	5	0	2
Alcoholism	18	7	12
General deviancy	16	35	26
Post-patient care	16	5	10
No answer	9	7	8
Total Per Cent	100 (44)	100 (46)	100 (90)

One reasonable explanation, it seems to me, is to account for these differences by training and experience. Public Health Nurses have a great deal of experience working with the communities' problems in the field while most of the Other Professionals, by the nature of their positions, deal with program administration. In addition, the Other Professionals are mostly medical doctors and thereby describe problems in diagnostic categories while Public Health Nurses use such categories with less frequency.¹ Without further study the relative effect of these

¹ It was pointed out by Hal Chandler, a psychiatrist, that the wording of the question may have produced these differences. I would certainly agree on that point but note that everyone answered the same question and that experience and/or training may account for the differential interpretation of the question. Only further study could establish the relative effect of these factors on the results obtained from this question.

factors cannot be established and we are left with speculation.

Some of the same differences can be seen in Table 4 where the judgments regarding the degree of local support by the Public Health Nurses are compared to Other Professionals. In general, the support is judged to be neutral or less, while only 65 per cent of the Other Professionals made a similar judgment. It can also be noted that only 10 per cent of the Public Health Nurses judged the support to be high or above while 31 per cent of the Other Professionals made such a judgment. Thus, we find again a contrast in the views of Public Health Nurses and Other Professionals in this sample. Whatever the reasons for these differences this study indicates simply that such differences appear in these data.

TABLE 4

A COMPARISON OF PUBLIC HEALTH NURSES AND OTHER PROFESSIONALS REGARDING DEGREE OF LOCAL SUPPORT FOR MENTAL HEALTH EFFORTS (JUNE-JULY, 1969; N = 90)

Degree of Local Support for Mental Health	Public Health Nurse Per Cent	Other Professionals Per Cent	Total Per Cent
None	5	0	2
Very low	25	22	23
Low	23	15	19
Neutral	32	28	31
High	9	24	17
Very high	1	7	4
No answer	5	4	4
Total Per Cent	100	100	100
Total Number	(44)	(46)	(90)

A comparison of the results in Table 3 with those in Table 4 reveals an interesting paradox.² In Table 3 we noted that the Public Health Nurses cite the Lack of Community Interest as a relatively minor problem (7 per cent) while the 15 per cent of the Other Professionals mentioned this as a problem. But in Table 4 we find that only 10 per cent of the Public Health Nurses judge the support for community efforts to be high or above while 31 per cent of the Other Professionals make that judgment. Thus, in one instance, the Public Health Nurse, we find a low mention of community interest as a serious problem but with a judgment of little support in the community. The Other Professionals mention this as a serious problem but find a high degree of support in the community. To speculate on the reasons

²I thank Hal Chandler for bringing this comparison to my attention and discussing the implications of these results with me, although he is not to be held responsible for the particular interpretation given in this paper.

for these results reveals something about this study and the differences between the two types of mental health professionals.

As mentioned earlier the question used to obtain a list of mental health problems was open-ended so as not to bias the responses. When faced with such a question a respondent's present activities are important in formulating an answer. It appears that compared with all the other problems and difficulties faced by the Public Health Nurse the abstract notion of community support becomes minor by comparison. On the other hand, the Other Professionals who are faced with administration demands see this as a very serious problem. Thus, the type of question used to obtain the list of problems coupled with the experiences of the respondents could have produced such results.

The latter question about community support was a closed-ended question with specific response categories. When faced with this type of question about community support specifically a different result can be anticipated. It is not a matter of a wide range of problems, but rather, a specific problem. When faced with this type of question the Public Health Nurses find little support in their daily activities while the Other Professionals find much more. The type of question could produce such apparent differences when comparing the results of the two tables.

There is another explanation for these results if one considers the types of questions to be relatively insignificant in producing such differences. This would be to account for these differential responses by the context of experience and behavior encountered in the daily routine of these two categories of mental health professionals. The Public Health Nurse is faced daily with problems of people in the field. She is attempting to solve such problems and sees these problems as quite significant. She recognizes that she has little community support but considers the problems *per se* to be of greater consequence to her daily activities than take abstract notion of community support or interest. The Other Professionals, on the other hand, are concerned with program development problems in which community interest and support are crucial. But their position makes them aware of the possible sources of support and the probability of it. They are also aware of the history of mental health efforts in their areas. Combining these factors they see community interest as a continual problem but know, in many instances, that the community is giving the maximum support it can at the present time. Thus, the apparent paradoxical results may be accounted for by the context of experience and behavior encountered by these two categories of mental health professionals. Only further systematic information relative to such ex-

periences could establish the plausibility of these explanations.

Finally, we should mention the results obtained from the questions regarding the voluntary associations/groups involved. Those that answered these questions named very few groups and the percentage of involvement did not exceed 50 per cent in most cases. The Mental Health Association or a Mental Health Council was mentioned as *most* involved while the number of names mentioned as *least* involved was so small as to be insignificant. Thus, these questions yielded very little in the way of useful information beyond that which is common knowledge among those who work in the area of community mental health.

Summary and Implications

This was a report of a mailed questionnaire study of professionals in the field of health and mental health in Georgia conducted between May and July, 1969. The returns came from about half of the counties in Georgia and the majority of those counties containing mental health programs. The majority of the respondents were Public Health Nurses. Although not a random sample, the conclusions can be seen as representative of those involved persons in health and community mental health.

The results show that the most serious mental health problems are: General Deviancy, Lack of Personnel, Lack of Community Interest, Lack of Facilities, Lack of Post-Patient Care and Alcoholism. Of these problems the Public Health Nurses mentioned Alcoholism and Post-Patient Care more frequently as the most serious mental health problem while the Other Professionals mentioned Lack of Community Interest and General Deviancy more frequently than the Public Health Nurses. The difference between the two categories of professionals was noticeable.

The difference between the two categories of professionals was apparent considering their judgments regarding the degree of support for local mental health efforts. The Public Health Nurses judged the support to be low while the Other Professionals judged it to be relatively high. A comparison between the results of the question dealing with mental health problems and the one dealing with local support was discussed in some detail. Although further study is required to clarify these paradoxical results it was speculated that the differential positions of the two categories of professionals in the mental health programs account for the differences in results. That is, the Public Health Nurse views community support as a minor problem when compared with the variety of other problems she faces in her daily activities but still recognizes that the communi-

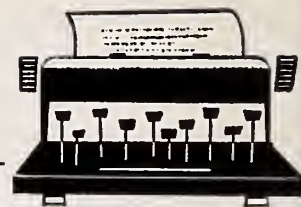
ty provides very little support. On the other hand, the Other Professionals who deal with program development problems realize community interest is a problem but find a greater degree of support for their program efforts from the community. Thus, the relative position in the scheme of mental health activities could account for these results but definite answers to this question require further study.

In sum, there are several implications that can be drawn from these findings without going beyond the data. First, it seems clear that Georgia has a variety of problems to solve in the field of community mental health. There is a need for more personnel and facilities to solve the problems of general deviancy and especially the problem of alcoholism. As more patients are released from Central State Hospital there will be a need for after care programs as well as an increase in short-term out-patient clinics. Second, in the development of future programs the multiple perspective within the field of community mental health should be taken into account. This study pointed to the differential views of Public Health Nurses and Other Professionals. Constructing these two categories actually reduced the complexity that is evident to most of the people who have worked in an area for even a limited period of time. Attention should be directed toward resolving these apparent differences and designing programs that are comprehensive and unified. Finally, this study made evident the necessity for more systematic information about community mental health in Georgia. The results suggested more questions than answers.

If those interested in this area of mental health can continue to obtain such information and maintain an inquiring posture many of the problems that are evident today will be gone tomorrow. This study was just a minor and preliminary effort in the quest for discovering and formulating problems in the field of community mental health. Hopefully, it will stimulate others to proceed toward obtaining more information and eventually solving the problems that people encounter in working out their everyday lives.

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**57th Annual
CLINICAL CONFERENCE
American College
of
Surgeons
October 18-22, 1971
Atlantic City, New Jersey**



Medicaid Review

FOR EVERY ACTION there is a reaction and for every pro there is a con. Certainly, the Georgia Medical Care Foundation, Inc., can expect some reaction to its efforts in peer review. It can further be expected that the reaction will be directly proportionate to the magnitude of the disallowances.

To accept any program we must operate from a basic set of principles. One of those principles is that only a physician is capable of judging the appropriateness of another physician's services. We no longer operate in a *caveat emptor* and *laissez faire* society. As a responsible profession we have the responsibility and duty to continually review ourselves and through this review to correct and teach and upgrade those among us whose practice patterns are not consistent with optimum standards.

The lay public sees the practice of medicine as an exact science, with no more than one way to cure a specific condition. The profession, however, knows and uses the art that accompanies the science in the treatment of disease. These factors make the process of peer review most difficult.

Specifically, Project Medicaid Review will review physician-generated services that fall outside of the parameters which we have provided for the use of the Health Department. These parameters are merely guidelines and have been developed from information generated by the practice patterns of a majority of the physicians of Georgia.

Our program will not review fees. These are fixed by the Health Department. We will review appropriateness of service and utilization. A non-indicated B12 injection is inappropriate whether the fee is two or ten dollars, just as injections cannot be considered the only route for the administration of medications.

The parameters for review have been mailed to all physicians, hospitals and nursing homes in Georgia that participate in the Medicaid program. Office visits and procedures as well as hospital stays which fall beyond the established parameters will also be monitored.

Those claims falling outside the established parameters are identified by the clerks at the Health Department and forwarded to the Georgia Medical Care Foundation, Inc. Skilled nurse consultants then screen those claims and compare them with guidelines which have been provided them. Their option is threefold:

- 1—Return to Health Department for payment.
- 2—Write the provider asking for more information.
- 3—Forward the claim to a physician consultant for his judgment.

The nurse consultant does not have the right to disallow a claim. This can only be done by physician action.

Claims will then be returned to the Health Department with the appropriate recommendation. The Health Department retains the right for final judgment on all claims.

Project Medicaid Review promises to be a significant item in the development of the Georgia Medical Care Foundation, Inc. The members of MAG are urged to give their cooperation and support to the activities of the Foundation in its endeavors to keep control of medicine where it belongs—in the hands of the physician.

Highlights of the AMA House of Delegates Meeting

IN ADDITION TO STUDYING, discussing in committee and acting on 158 items of business that came before it at the 120th Annual Convention, the AMA House of Delegates heard a stirring speech by the President of the United States as well as outlines of the future as seen by both outgoing and incoming Association presidents.

Meeting for a total of 13 hours and 53 minutes, the House acted on six special reports; 31 reports from the Board of Trustees; two from the Council on Constitution and Bylaws; four from the Council on Medical Education; one from the Council on Long Range Planning and Development, and 104 resolutions.

President Nixon

The unmistakable highlight of the entire five-day meeting was an address by President Richard Nixon to the House of Delegates and an overflow crowd of guests.

The great bulk of the President's address was a challenge to America's physicians to assume leadership in curing and preventing drug abuse. Mr. Nixon told his audience that "The best way to end drug abuse is to prevent it, and America's doctors are the indispensable front-line soldiers for success in this all-important battle." The House of Delegates responded to the President's challenge by adopting a policy statement that calls for strengthening and expanding the AMA's program on drug dependency. (Other actions related to drugs appear later in this report.)

In addition, Mr. Nixon addressed himself extensively to the current debate on national health insurance, emphasizing that he believes "that the most expensive plan that has been offered—a plan for nationalized, compulsory health insurance—is the plan that would actually do the most to hurt health care in this nation."

Such a plan, the president said, "would exact a very high price from our people in terms of dollars and cents. But it would exact an even higher price in terms of the quality of American medicine." (This was an obvious reference to the so-called Kennedy national health insurance bill.)

Mr. Nixon emphasized that America's health care system needs reform. But, he added that "We can never improve our country's medical system by working against our country's medical profession. No system of health care will ever work unless the doctors of the nation make it work. So let us work together," he said, "for a system—a system that will continue to provide for choice, that will continue to provide for quality and one that will at the same time deal with the pressing problems of costs in an effective way that will not destroy quality."

Drugs and Drug Abuse

In addition to the action taken in direct response to President Nixon's speech to the House, delegates also took several other actions on the subject of drugs and drug abuse.

A report of the Council on Mental Health and its Committee on Alcoholism and Drug Dependence was filed for the information of the Association. It contains these recommendations for the medical profession:

1. Increased attention to alcoholism and drug abuse in the curriculum of medical schools.

2. Medical students, interns and residents should be encouraged to associate themselves with "street clinics" to establish links between the profession and young drug abusers.

3. Continued development and dissemination of reliable information to physicians and other health professionals.

4. Laws and regulations should be modified to recognize alcoholism and drug dependence as illnesses.

5. Closer liaison between medical societies and law enforcement and licensure bodies to deal jointly with the problem of physicians suspected of professionally misusing or personally abusing drugs.

6. Continually up-dated factual material for public consumption.

7. Increased emphasis on the responsible use of drugs for therapeutic purposes, both by the public and by physicians.

The House resolved to follow "studies being conducted to ascertain the relationship between proprietary drug advertising in the mass media and excessive use of self-prescribed drugs and drug dependence problems" and to "cooperate in every way possible in the studies being conducted by the FTC to assure the enactment of proprietary drug advertising regulations in the interests of protecting consumers."

Delegates also resolved to "urge all physicians to limit their use of amphetamines and other stimulant drugs to specific, well-recognized medical indications."

In addition, the House resolved to go on record "favoring the implementation of stern measures for narcotic traffic control in Vietnam, as well as measures for the identification, prevention, diagnosis and adequate treatment of addicts within the armed forces, with adequate provision for the availability of proper follow-up and aftercare."

Peer Review

The subject of Peer Review received considerable attention by the House, both as a reflection of the recognized impact it will have on the practicing profession and also out of a need to reach a profession-wide consensus on the matter. As a result, the House adopted three important definitions in the area of peer review and a subsequent statement:

DEFINITIONS

"Peer Review: Evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis; inpatient hospital and extended care facility utilization review; medical audit; ambulatory care review; and claims review are all aspects of peer review.

"Medical Practice Analysis: A function of the medical society, or other organization authorized by the medical society, designed to coordinate all peer review efforts of a community. Medical practice analysis focuses on the development and application of criteria for optimal medical care, and evaluates the individual and collective quality, volume and cost of medical care, wherever provided.

"Claims Review: Peer evaluation and adjudication of claims questions referred for peer review by any party with a valid interest in the case."

PEER REVIEW STATEMENT

"That the American Medical Association and its constituent state associations reaffirm their support of voluntary mechanisms of review and education by physi-

cians such as grievance committees, insurance review committees, and the numerous hospital review mechanisms, many of long standing;

"That the AMA and its constituent state associations continue to stress that peer review shall be considered a professional function, and as such shall be carried out by physicians or under the sponsorship of the county and state medical societies;

"That this House of Delegates call on all state and county medical societies and the AMA to take an active responsible role in peer review and to document for the information of the public current functioning procedures and programs which are serving in the interests of delivering good medical care."

Teenage Pregnancy

With respect to teenage pregnancy, the House adopted the statements that "The teenage girl whose sexual behavior exposes her to possible conception have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs" and "The physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his best medical judgment in the best interests of his patient." Earlier in that report, the House inserted the statement that "definite effort should be made to obtain consent from the minor's parents or legal guardian whenever possible."

Regional Newborn Intensive Care Facilities

Regarding maternal and infant care, the House adopted a report pointing out that "Application of recent advances in scientific knowledge and skills in the intensive care management of high-risk pregnant women and high-risk newborn infants will result in reduction of present maternal and infant mortality. A major contribution to such a program is the development of a centralized community (or regional) hospital-based newborn intensive care unit. Concentration of high-risk infant care programs in hospitals especially staffed and equipped to provide optimal care is a proven life-saving mechanism for infants at risk."

Venereal Disease

Concerned with the spread of venereal disease, the House resolved: That medical societies be urged "to support education of patients and the public through more extensive and more imaginative use of all available media and through school curricula"; that the AMA "reiterates its support and cooperation with the National Commission on Venereal Disease in order to hasten the control of these diseases"; and that the AMA "strengthen in every way possible research efforts toward the development of vaccines for the active immunization of our population against venereal disease."

Physician's Assistant

Considering the use of assistants in medical practice, delegates resolved that "the physician may properly delegate technical procedures to an allied health worker" but affirmed the principle "that whatever privileges may at any time be granted either to allied health workers or to independent limited practitioners, by law or otherwise, such grant in no way circumscribes the physician's authority in that field and in no way restricts the practice of medicine by the physician."

Elections

Charles A. (Carl) Hoffman, West Virginia, was elected President-Elect, and will be installed as the 127th President of the AMA in June, 1972.

Ralph C. Teal, California, was elected Vice President, and Russell B. Roth, Pennsylvania, and J. Frank Walker, Georgia, were unanimously re-elected Speaker and Vice Speaker, respectively, of the AMA House of Delegates.

Wesley W. Hall, Nevada, was installed as President of the AMA.



COMPULSORY HEALTH INSURANCE

JUST THE OTHER DAY I came across a speech that I made to a local civic club on July 7, 1949, a little better than 22 years ago. As I recall, I spent some time with the preparation of this speech, and in delivering it I gave it my best hell-fire and brimstone treatment. I well remember the reaction to the speech was sort of ho-hum and "You don't really believe that's gonna happen in *this* country, now do you?" The topic was "Compulsory Health Insurance." It was a 30-minute speech documented with all the statistics and references that I could come up with at that time. Obviously, to cover it in its entirety would be too much for this page, so I'll give you the main parts and let you make your own comparisons of the thinking at that time with that of today, noting what has happened in these 22 years, and what we still have to look forward to.

Compulsory Health Insurance—7-7-49

I believe that the most vital and the most dangerous issue confronting the American people is the question of whether or not this nation, with its tradition of freedom and private enterprise, its foundation of personal liberty and individual initiative, should adopt this program of National Compulsory Health Insurance. This is a plan for Government control and direction of all doctors, hospitals, druggists, and medical schools, which originated in Germany in 1883 and later was embraced by Soviet Russia, Socialistic Great Britain, and many other foreign countries.

The present agitation in favor of Government medicine stems from a report to the President of the United States by Mr. Oscar R. Ewing, Federal Security Administrator, on Sept. 2, 1948, entitled "The Nation's Health." Legislation to carry out this plan was presented, but due to the pressure of other matters, it never came to the floor for discussion. But, fear not, with your tax money to back their campaign and push their propaganda down the throats of an unsuspecting public, it will be back again and again until congress does something about it.

This program could not provide us with FREE medicine, which is the frequent implication of its proponents. It would be financed by another payroll tax taken out of the paycheck of every American worker. It would provide low quality medicine at a very high cost. In other countries, it has been found to take one clerk or executive for every 100 people served by this program. In this country of 148,000,000 people, this would mean one and a half million paid government employees to check the records and police the work of 170,000 doctors.

With one and a half million non-medical checkers, can you imagine just how confidential your trips and conversations and treatments with your physician would be kept? Could these workers be paid and your drugs and medical fees be taken care of at a fraction of the cost that you now pay for service under the fee system? The only promise that is made to you under this system is "Reasonable Medical Care with the Money Available." Who would decide what is reasonable medical care? You, or your physician? No, you know the answer—it would be the politicians. And how long would the money be available with one and a half million non-medical workers to be paid out of the funds? The doctors' time would be taken up with filling out forms. Every visit would have to have a form filled out in triplicate and many patients would seek medical care for trivial or imaginary ailments because they thought it was free.

Gentlemen, with all these facts, they still say that you will get something better and far cheaper and even go so far as to try to make you believe it would be FREE. There

may be those of you who feel that the doctors are bitterly opposed to this system because they are having their candy taken away from them. But, it was Lenin, one of the gods of the Marxist party line, that laid down this fundamental precept, "Socialized medicine is the keystone to the arch of the Socialized State." This system means the development of a wholly un-American health program, topped by a medical commissar in Washington, and regulated by a board of petty bureaucrats throughout the land. However evil and offensive this may be, it marks only the beginnings. When government socializers take the initiative and freedom from one group of citizens, they invariably move against the others also. If doctors and dentists lose their fundamental American right, WHO WILL BE NEXT? Lawyers, architects, journalists? The answer is simple—YOU may be next.

Kinda like watching an old movie on TV, wouldn't you say? See you next month.

W.C. Mitchell

W. C. Mitchell, M.D.

President, Medical Association of Ga.

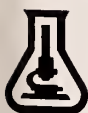
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SOCIETIES

The **Wayne County Medical Society** conducted a course in Cardiopulmonary Resuscitation in June for members of the Jesup fire and police departments, as well as members of the local rescue units.

PERSONALS

First District

Walter Brown was sworn in by Gov. Jimmy Carter in June as a member of the State Workmen's Compensation Medical Board.

Third District

Vernon J. Grantham has been elected to active membership in the American Academy of General Practice.

Fourth District

Reuben Castillo was elected to active membership in the American Academy of General Practice in June.

Fifth District

Omer L. Eubanks has been re-elected to active membership in the American Academy of General Practice.

J. Watts Lipscomb has been named chief of staff for South Fulton Hospital for 1971-72.

Seventh District

Donald W. Schmidt was elected as Lions International Director in June at that organization's 54th Annual Convention in New York.

Eighth District

Eugene D. Bell has passed the certifying examination of the American Board of Family Practice and is certified as a Diplomate.

Floyd Eugene Davis has been re-elected to active membership in the American Academy of General Practice.

Tenth District

Menard Ihnen was guest speaker at the June meeting of the Augusta League of Nursing.

Charles Gray Green has been re-elected to active membership in the American Academy of General Practice.

James Hubert Milford has been re-elected to active membership in the American Academy of General Practice.

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THE MONTH IN WASHINGTON

The Congress has been asked by the Administration to authorize an additional expenditure of \$155 million for the control of drug addiction. In his special message to the House and Senate, President Nixon said: "If we cannot destroy the drug menace in America, then it will surely destroy us."

The Administration's program would:

—Make Veteran's Administration facilities available to all former servicemen in need of drug rehabilitation regardless of the nature of their discharge and provide \$14 million for this program.

—Seek \$105 million from Congress to be used solely for treatment and rehabilitation of drug addicts.

—Request an additional \$10 million to improve education programs on dangerous drugs.

—Request special legislation permitting the government to use information obtained by foreign police and other technical measures to make it easier to prosecute drug pushers.

—Ask for an additional \$25.6 million for the Treasury Department to expand efforts against smugglers.

—Request \$2 million to expedite research and development of detection equipment and techniques.

—Request \$2 million for the Agriculture Department to develop herbicides that would destroy narcotics-producing plants.

—Request \$1 million for assistance to other nations in training law enforcement officers.

Methadone Endorsement

Implicit in the Presidential drug control proposal is the endorsement of the use of methadone in the treatment of Vietnam veterans addicted to heroin. This high level sanction of the heretofore somewhat controversial and experimental use of methadone marks a turning point in the nation's attempt to rehabilitate addicts. Observers believe the decision to make wide-scale use of methadone was influenced by official recognition of the discouraging low "cure" rate from other approaches to the problem.

Named by the President to head the new drug control program was Jerome H. Jaffe, M.D., a Chicago psychopharmacologist and director of the Illinois State Drug Abuse Program. Dr. Jaffe, an advocate of the methadone treatment method, will serve as a White House consultant until the new agency is organized.

Asks AMA Help

Shortly after the announcement of the new drug control program, President Nixon asked the American Medical Association's House of Delegates meeting in Atlantic City to join in the nationwide war on drug abuse.

After detailing at some length the growing social dangers of drug abuse, the President said that there was a link between the inappropriate use of drugs within the medical context and the abuse of drugs outside that context.

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Cover

An artist's rendition of one of the many meetings of Committee Conclave depicts the action and involvement of MAG's members in the activities of the Association. Turn to page 320 for a comprehensive round-up of the results of MAG's fourth annual conclave. Cover by Robert Hamill, Atlanta.

Right Lower Quadrant Mass in a Child

ELISE NEELD, M.D., LOUIS MARTIN, M.D., and H. S. WEENS, M.D., Atlanta*

DR. NEELD: The patient is a three-year-old male with a one-week history of abdominal pain. The father noted a "knot" in the child's abdomen and the patient was brought to the Pediatric Emergency Clinic three days prior to admission. An appointment was given to return to the clinic the following morning. This appointment was not kept. The patient began to have diarrhea and showed decreased tolerance to play and decreased appetite for three days prior to admission.

On physical examination there was no evidence of fever. The abdomen showed distention and a firm 7 x 9 cm. irregular mass was palpable in the right lower quadrant. This mass could not be separated from liver or kidney on physical examination. The patient was admitted to the hospital and emergency IVP was ordered.

Discussion

DR. MARTIN: On the preliminary film of the abdomen, there is marked small bowel distention. There is a very small amount of gas in the rectum, otherwise no large bowel contents can be identified. There is a large mass in the right abdomen measuring 7 x 5 x 8 cm. After injection of the contrast material, renal function and anatomy is demonstrated to be symmetrical and normal (Figure 1).

DR. NEELD: The intravenous pyelogram was followed immediately by a barium enema. Would you comment on these films? (Figure 2).

DR. MARTIN: The cecum and proximal right colon are poorly filled and are compressed in a fixed manner in their sagittal plane. The mucosa of the involved bowel appeared intact; however, the mucosal folds appeared stretched and edematous.

The lesion as demonstrated by the IVP and barium enema primarily involved the cecum and as-



FIGURE 1

I.V. urogram demonstrating normal upper urinary tracts. There is marked small bowel distention and a poorly defined mass is present in the right abdomen.

cending colon. The lesion has caused obstruction to the colon either by direct involvement or compression. This tumor is extrarenal. It compresses the right colon from both its medial and lateral surfaces which makes a primary liver mass unlikely.

Lesion Consideration

In a three-year-old child the two most likely lesions that would obstruct the colon would be intussusception and pericecal abscess (most usually

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements, Jr. and H. S. Weens.



FIGURE 2

Barium enema demonstrating a string-like deformity of the cecum and ascending colon indicating infiltration of the bowel wall.

secondary to ruptured appendix or foreign body perforation). The radiographic pattern excludes intussusception. The patient's clinical course would rule against an acute or subacute inflammatory disease, such as cecal or appendiceal perforation, amebiasis or tuberculosis. Granulomatous ileocolitis would be a possibility but most unusual in a patient of this age. Having ruled against the above mentioned diseases, I am left with the most likely possibility, that of neoplasia. Carcinoma is very rare in this age group, however, sarcoma would present in this manner. The most likely of the sarcomas would include rhabdomyosarcoma, lymphoma or a mixed mesenchymal sarcoma. Neuroblastoma would be less likely without renal displacement. Obstruction would be secondary to lymphomatous involvement within the bowel wall or direct extension from a retroperitoneal focus.

DR. WEENS: Would amebiasis or granulomatous colitis produce such a sharply defined localized mass?

DR. MARTIN: I doubt it. Of course, there can be marked edema of the bowel wall but I do not believe that this rigid pattern would be produced.

DR. CLEMENTS: In adults, amebic infestation of the colon may be secondarily infected and produce

a granuloma which can simulate carcinoma or other neoplasms. However, I don't believe that in a child an ameboma would be very likely to occur.

DR. NEELD: The patient had surgery the day following the x-ray examination. A right cecal mass was discovered with near complete obstruction at the ileocecal valve. A right colectomy with ileo-transverse colostomy was performed. Histologically, the tumor was poorly differentiated lymphocytic lymphoma (Figure 3). The bone marrow examination was negative.



FIGURE 3

Surgical specimen demonstrating lymphosarcoma infiltrating the cecum, appendix and distal ileum.

DR. PETERS: This infant was presented to the tumor conference. Initially, the lesion was thought to be confined to the cecum. This type lesion which is localized in the intestinal tract, even in this age group, is considered to have a good prognosis. On review of pathological material, a single node was discovered to be involved and the patient is presently undergoing radiation therapy.

Comment

By far the most likely mass lesion with the radiographic appearances described above is paracecal inflammatory disease, usually produced by appendicitis with rupture and abscess formation. In the

absence of clinical evidence of inflammatory process, neoplasia should be considered.

Excluding colonic polyps and duplication cysts, tumors of the G.I. tract in children are frequently malignant and must be considered so until proved otherwise. These usually present with palpable abdominal mass, bleeding or obstruction. By far, the most common malignant tumor of the small intestine and colon in children is malignant lymphoma. The most common sites are lower ileum and cecum and the ascending colon.¹

Emory University 30322

REFERENCE

1. Landing, B. H. and Martin, L. W.: Tumors of G.I. tract and pancreas; *Ped. Clinics of N. Am.* 6(2):413, 1959.

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ALEX T. MURPHEY, M.D., *Augusta*

THE HALLS of the University Hospital are crowded tonight. Someone said something about only 100 patients. But, you see, we are talking about the Old University.

For the first time in 60 years, the ghosts can walk unshackled in the halls. They walked at times before. They haven't been hard to see, especially after losing a night or two of sleep. They stayed away from people, in the back halls and empty departments in the night. An emergency—you had to go for something and they were there. You could see them sometimes, but mostly simply hear—the X-ray Department or down in the Morgue—they were there, but very quiet and unobtrusive.

Tonight they gather in the halls. There is a clinic in the classroom. The Old Chief and students arrange the patient to best advantage in the ghostly light. Litten's sign might otherwise be missed. A young Nutritionist looks with joy on thousands of patients with pellagra. Sometime during the evening vitamins will become available and those ghostly, ghastly complexions and minds will clear by magic.

Not all the spirits are ghosts. There are those who, still alive, are there in spirit. There is a whisking sound of starch as the night supervisor parades the halls. Medical students courting nurses slip quietly out of sight at the sound of her skirts. The telephone

operator keeps watch on her, but not with much success.

There are other ghosts as well. Diseases and treatments nearly dead or dead emerge to scourge again. Typhoid, typhus, lobar and malaria. Across the court by gas light, bodies naked to the waist stand in a circle, each rubbing blue mercury into the back of the one ahead. The tubs are out with hot and icy water. An older man drips ether from a can and reminisces on Crawford Long's first paper. A nursery epidemic flares like fire.

A baby strains and takes a breath and cries—to later lie in Flander's Field, Okinawa, Seoul or Nam. Much humanity here—often disguised by rough, ironic humor by the staff. Better to laugh than to cry. Here there has been much of both. The breathing stops and loved ones gasp and accept the unacceptable. Life begins a floor away with pink and blue and smiles and cheer and laughter.

Yes, all are here. Doctors, nurses, orderly, aides, technicians, patients, family, friends. And Spooky comes from underneath the stairs and calls the Outside Medicine Man again. A student fails. Another passes out at Anna's party, and someone calls the roll and it is long—long—long.

So might it be.

1134 Druid Park Avenue 30904

This paper treats a sensitive socioeconomic question in an objective manner—free of the emotional bias which sometimes enters into discussions of social problems.

Prescription Prices, Race and Attirement

CHARLES L. BRAUCHER, Ph.D.,[†] and JEFFREY A. KOTZAN, Ph.D.,[‡] Athens

A CHARACTERISTIC of the inflationary period in which we are living is the preoccupation of the average American citizen with the price of food and drugs. Both commodities have been thoroughly cataloged with various economic indices showing their year-by-year performance as a group. More recently, increased attention has been focused on socioeconomic variables which may or may not exist within each commodity grouping. Thus, studies have been conducted which investigated such variables as store location, store type, economic level of customer, and race.

A study of the food purchase patterns available to the inner city poor led Dixon and McLaughlin to conclude that their results failed to support the hypothesis of price discrimination against low income families and that "price differences for comparable products are explained by the type of store rather than by store location."¹ Goodman investigated food prices in a low-income area of Philadelphia and found that "because (the residents) shop at competitive stores, going outside of their residence area to do so if necessary, the poor do *not* pay more for food in (the low income) area."²

The price situation in the prescription drug category tends to agree with the research findings in the food sector concerning the variable "store type." Azarnoff, Hunninghake, and Wortman compared prescription drug prices at nine pharmacies of two drug chains with 14 independently operated pharmacies and found that the cost for each prescription (generic and brand name) was higher at pharmacies composed only of prescription shops and other individually operated drug stores.³ Another survey related prescription price to store type, as determined by the size shopping center in which the pharmacy was located. In this study store types

ranged from neighborhood shopping center drug stores (consisting of up to 15 stores and a trade area of 3,000-20,000) through community shopping center stores to regional shopping center drug stores (which consisted of more than 40 stores and a trade area of at least 150,000). The average 1968 prescription price ranged from a low of \$3.31 in the neighborhood shopping center drug stores, through \$3.45 in the regional shopping center stores to \$3.61 in the community shopping center stores. The same survey reported an average prescription price of \$3.41 in all shopping center drug stores compared to an average price of \$3.53 in non-shopping center stores.⁴

Location Factor

A prescription drug study recently completed in Detroit inferred that store location could not be completely ruled out as a factor affecting the price of prescription drugs. In this study shoppers had prescriptions written for 12 capsules of Darvon Compound-65 and had them filled in Detroit pharmacies. The results, as reported, indicated that "in every case the highest price was found in the inner city." The investigators then interjected two "relatively new" dimensions into the prescription price controversy by stating that "a low price was never found in the very poor or low income black areas."⁵

Although the Detroit study inferred that the variables of economic level and race were influential in determining prescription prices, specific analysis leading to this conclusion was lacking. The Dixon-McLaughlin study, cited earlier, also mentioned the possibility that there are forms of discrimination practiced which had not been determined in their study.⁶ An investigation of exploitation in the market place conducted in Oklahoma City by Kangun found that "the relationship between race and exploitation is attributable to the higher incidence of poverty among minorities and not a result of some insidious form of racial discrimination."⁷

Finally, Hastings and Kunnes reported the results of a study of the relationship between pre-

* This investigation was supported by PHS Grant Number CH00456 from the National Center for Health Services Research and Development.

[†] Associate Professor of Pharmacy Administration, School of Pharmacy, University of Georgia.

[‡] Assistant Professor of Pharmacy Administration, School of Pharmacy, University of Georgia.

scription prices and such variables as neighborhood income, type of pharmacy ownership, type of merchandise sold in each pharmacy surveyed, and concentration of nearby pharmacies. The additional variables of race and attirement were tested by the use of well dressed white purchasers and poorly dressed Negro purchasers who presented prescriptions for 100 tablets of digoxin (Lanoxin) in 40 urban pharmacies. Among the findings was the observation that "twenty-three per cent of the time, poorly dressed Negro purchasers were charged at least 15 per cent more than well dressed white purchasers. In every case the Negro purchaser paid more than the white purchaser at small independently owned variety drugstores in poor neighborhoods with few nearby competing pharmacies." The investigators concluded that the data "suggests that the race or appearance of the purchaser may importantly influence retail prescription price."⁸

Discussion

The studies previously cited appear to lead to the conclusion that various socioeconomic and physical factors such as neighborhood income, type of ownership, merchandise mix, competition, store location, size of shopping center, attire of purchaser and race of purchaser are all operating to influence the price which the public pays to have a prescription filled. While factors such as store type, ownership, trade area income, competition, location, and shopping center size may operate to influence prescription price, such differences could be explained, in part, by economic variables. The additional factors of race and attirement, however, would suggest discrimination if these factors were found to have a significant influence on the prescription charge. It is for this reason that the study by Hastings and Kunnes deserves further investigation.

The Hastings-Kunnes study, although lacking a firm conclusion, infers that race and appearance influence retail prescription prices. When the methodology and results of the Hastings-Kunnes study are considered such a suggestion cannot be substantiated. Because of the multiple variables which were operating, the significance of findings attributed to race or attirement must be questioned. Also, within the race-attirement variable combination, one could logically question whether the Negro students were charged more for their prescriptions because they were black or because they were shabbily dressed. Conversely, were the whites charged less because of their skin color or because of their neat attire?

Methodology

The objective of this study was to determine if price discrimination exists in the purchase of a high-

volume prescription drug in the Metropolitan Atlanta area. The study was designed to isolate both consumer and institutional factors and the interaction of factors contributing to possible price discrimination. The factors included in the design were race, attire, and store-type.

A complete three-factor factorial design was selected for an analysis of variance. Race and attire were used as separate primary effects in order to isolate a possible significant race-attire interaction of price discrimination.

Four white and four Negro undergraduate university students were employed to make multiple purchases of a given prescription drug. Two of the white students and two of the Negro students were randomly selected to play the role of a poorly attired purchaser. The dress for this role was specified as an old sweat shirt, jeans, and old shoes without socks. The four remaining students were instructed to dress in a coat and tie. Once assigned to a particular mode of dress, the students remained in that mode for the duration of the experiment. Sufficient instructions were given so as to insure the success of the intended purchaser roles.

Store Types

The institutional factor of store-type was assigned three levels. The major criterion of classification was assumed consumer appeal. The first level of the store-type factor was assigned to professional pharmacies—those which appeal to the urgent need of health care consumers to receive their medication immediately after receiving the prescription from the physician. The second level of store-type was assigned to the traditional-community pharmacy which serves the general health needs of the community. The third level of store-type was assigned to promotional-discount pharmacies which feature the consumer appeal of price discounts.

A complete list of all 317 pharmacies in the Metropolitan Atlanta area as of March, 1969 was obtained. The list was divided into the three predefined levels of store-types using the perceivable physical store characteristics. Classification conflicts were resolved by the investigators on the basis of the major criterion of probable consumer appeal.

Twelve stores were randomly selected from each of the three categories of store-types. Therefore, the sampling plan made no attempt to stratify the pharmacies into various census tracts, as the Hastings-Kunnes study did. Rather, the sampling design represents all Metropolitan Atlanta pharmacies regardless of location within the city. This arrangement was selected because of the assumption that residents of a given urban area usually have considerable mobility and are therefore not necessarily con-

fined to the geographical limits of the census tract in purchasing prescription medication. Some minor complications were introduced into the experimental design because the stores were chosen randomly while race and attire were selected factors. To compensate for these considerations a mixed experimental design was employed.*

Written prescriptions for 12 Darvon Compound-65 Pulvules were obtained from three centrally located physicians in Atlanta. These prescriptions were then used by the students for the drug purchases. Darvon Compound-65 was selected as the prescription drug to be purchased because it was the most popular analgesic prescription drug dispensed in the United States and ranked third in the number of all prescriptions dispensed at the time of the experiment. Prescription purchases were executed on four successive weekends in July and August of 1969. Each of the 36 sample pharmacies were assigned four visits by the students which resulted in a total of 144 prescription purchases. Thus, each pharmacy received identical prescriptions, spaced over a period of four weeks, from a well dressed Negro, a poorly dressed Negro, a well dressed white, and a poorly dressed white. The order of the racial-attire purchases was randomized for each of the sample pharmacies and balanced among all sample pharmacies each week by the use of a random set of Latin squares.

Results

All prescription purchases were completed as scheduled and all prescriptions were dispensed with the proper drug, quantity and label instructions. An analysis of variance (Table 1) showed that race, dress, and the interaction of race and dress proved to be totally insignificant as pricing differentials of the Darvon Compound-65 prescriptions. The magnitude of the race and dress factors would be reduced further by corrections for imperfect random sampling. The store factor was not affected by the correction. The store-type factor proved to be the only significant factor of the experimental design.

In order to demonstrate the significance and non-significance of the three factors, the entire experiment is averaged in Table 2. The data clearly reveals that the Metropolitan Atlanta pharmacies did not discriminate with prescription prices of Darvon Compound-65 on the basis of race and dress. Those price differences which occurred derived solely from

TABLE 1
ANALYSIS OF VARIANCE

Source	SS	df	MS	F
A (Race) .	200.6944	1	200.6944	.1315
B (Dress) .	42.250	1	42.250	.02770
C (Store-Type) ..	79,552.0555	2	39,776.0277	26.06*
AB (Race-Dress) .	.4445	1	.4445	.0002914
AC (Race-Store) ..	789.0556	2	394.5278†	
BC (Dress-Store) ..	393.50	2	196.750†	
ABC (Race-Dress-Store) ..	3.3889	2	1.6944†	
Within Cell	201,354.50	132	1,525.4128	

* $F_{.99(2,132)} = 4.79$.
† Deleted from the model.

the type of pharmacy operation. For example, the professional pharmacy charged an average of \$.54 more for the prescription than did the promotional-discount pharmacy and \$.10 more than did the traditional-community pharmacy. The analysis of variance (Table 1) concluded that the store factor was highly significant and the averages shown in Table 2 depict the strengths and direction of the significance.

Although the influence of the economic condition of the metropolitan areas used in this study was not measured, the possibility of the effect of this factor on the prices charged for prescriptions was not ignored. Three of the 12 traditional-community pharmacies were judged by the students and investigators to be located in the most economically depressed area of Metropolitan Atlanta. The prices charged by these pharmacies were isolated to compare the results of this study to that of Hastings and Kunnes which isolated price discrimination in the low income area, traditional-community pharmacies. The prices charged by the three Atlanta pharmacies were studied by a two-factor analysis of variance. The results of the analysis were totally insignificant. Analogous to the study as a whole, race, dress, and race-dress interaction were not causes of price discrimination in the three traditional-community pharmacies located in the economically depressed areas of Atlanta.

Discussion and Conclusions

There are two major points to consider in relating the results to the research design. First, the statistical significance of the price differences associated with the store factor does not explain the causes of prescription price differences among the three store-types. Although this study did not at-

* Winer's Type 2 Design was used. See Winer, B. J., *Statistical Principles in Experimental Design*, Chapters 5 and 6, New York, McGraw-Hill Book Company, 1962.

tempt to determine the causes of the price discrimination related to store-type, a few observations as to possible causes may stimulate further research in this area. In this respect, one must consider important marketing factors such as differences in purchasing practices, promotion practices, and customer services offered—for example: charge accounts and prescription delivery service. Also, there are additional professional services such as family drug records which provide the pharmacist with a therapeutic profile from which he can intelligently consult with both the patient and his physician regarding drug therapy. All of these services must be financed and the prescription price differentials could reflect the cost of these additional services.

TABLE 2
AVERAGE PRESCRIPTION PRICES

Factor	Average Prescription Price
Race (not significant)	\$1.95½
White	\$1.97
Well dressed	\$1.96
Poorly dressed	\$1.97
Black	\$1.94
Well dressed	\$1.94
Poorly dressed	\$1.95
Dress (not significant)	\$1.95½
Well dressed	\$1.95
White	\$1.96
Black	\$1.94
Poorly dressed	\$1.96
White	\$1.97
Black	\$1.95
Stores (significant)	\$1.95½
Professional	\$2.17
Traditional-community	\$2.07
Promotional-discount	\$1.63

The second point is that the implication of the results should not be extended beyond the experimental design. Only one very popular drug was included in the study. Race and dress discrimination may exist with less popular drug items where consumer price comparisons are not available. Also, the experimental design did not address itself to determining where the indigent shop. The indigent may pay more for a prescription of Darvon Compound-65 because of where they are rather than what they are.

The results of this study show that the race and attire of a prescription purchaser had no influence on the determination of retail prescription price in Metropolitan Atlanta pharmacies. Only the factor of store-type contributed to prescription price discrimination.

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ABSTRACT

The objective of this study was to determine if price discrimination exists in the purchase of a high-volume prescription drug in the Metropolitan Atlanta area. The study was designed to isolate both consumer and institutional factors and the interaction of factors contributing to possible price discrimination. The factors included in the design were race, attire, and store-type. Four white and four Negro undergraduate university students were employed to make multiple purchases of a given prescription drug. Of these, two Negro and two white students played the role of a poorly attired purchaser and two white and two Negro students played the role of a well-dressed purchaser. Each student had the selected prescription filled in each of 36 pharmacies, which were evenly divided into three pre-defined levels of store-types using the perceivable physical store characteristics. The results of this study show that the race and attire of a prescription purchaser had no influence on the determination of retail prescription price in Metropolitan Atlanta pharmacies. Only the factor of store-type contributed to prescription price discrimination.

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*Early detection of these defects can result
in prevention or alleviation of many
previously untreatable inborn errors.*

Perinatal Diagnosis of the Inborn Errors of Metabolism

LOUIS J. ELSAS, II, M.D.,* *Atlanta*

GR^{EAT} EMPHASIS has been placed in recent years on the prevention of disease through selective screening and early recognition. Dr. Jacobson has described the techniques of prenatal diagnosis using amniotic fluid cells to obviate the recurrent psychosocial and economic travails incumbent on the birth of children with untreatable chromosome abnormalities. The "prevention" we speak of in this group of disorders remains one of combining the predictive power of genetics with tissue culture, cytogenetics, and obstetrical expertise to offer termination of pregnancy to mothers carrying demonstrably defective fetuses. In another group of disorders, "the inborn errors of metabolism," prevention is beginning to take on an entirely new meaning.¹ This group of disorders is no longer restricted to blocks of enzyme anabolism or catabolism as originally described by Garrod in 1904. Today these diseases encompass several hundred conditions resulting from defective genetic control of proteins which may be structural (hemoglobin, globin), ion binding (ceruloplasmin), serum proteins (antihemophilic factor), or membrane carrier proteins (permease), as well as catalysts of intracellular metabolism.

"Inborn errors" are now demonstrable in transport reactions, cofactor binding, oxygen or ion carrying functions, and many other vital functions in addition to the classical "block in reaction sequence" model. The availability of blood and urine screening programs has resulted in large scale detection of asymptomatic and symptomatic affected patients and heterozygous carriers. Specific dietary, drug, and replacement therapy can prevent or alleviate many previously untreatable inborn errors (phenylketonuria, hemophilia, Maple Syrup Urine disease, galactosemia, methylmalonic aciduria, Wilson's disease, etc.). However, the ability to prevent these defined

inborn errors or their sequelae requires crucial insight into the mechanisms producing disease, prediction through a knowledge of the mode of inheritance, and institution of appropriate treatment before the disease is clinically manifest. We will review the national experience in the prenatal diagnosis of inherited metabolic diseases.^{2, 3} In addition, we will discuss the clinical application of neonatal or perinatal diagnosis in a family with galactosemia¹ and Maple Syrup Urine disease⁵ which resulted in true "prevention."

Errors Discovered

The 13 inborn errors which have been discovered *in utero* using amniotic fluid are listed in Table I. The enzymatic methods used involved many different laboratories and investigators with expertise in the particular defective pathway. Diagnoses were established in some by demonstrating defective enzymatic function in fibroblasts cultured from "high risk" pregnancies as compared to normal amniotic fluid cells obtained from normal fetuses at a similar gestational age. In Pompe's disease, galactosemia, X-linked hyperuricemia, lysosomal acid phosphatase deficiency, Tay-Sachs, Niemann-Pick, Gaucher's, Hurler's, Fabry's disease, and metachromatic leukodystrophy, defective enzymatic functions have been identified *in utero*. In others not listed (Maple Syrup Urine disease and homocystinuria) normal pregnancies have been monitored and brought to term when normal enzyme activity was found. Eight weeks may be required to cultivate enough fibroblasts for enzyme analysis, and if fluid is obtained after the 18th week of gestation, diagnosis may not be available in time to offer termination of pregnancy. Thus, direct analysis of fetal cells, enzyme, or biochemical content of amniotic fluid could enhance the speed with which diagnoses are made. Pompe's disease, Tay-Sachs disease, and Hurler's syndrome have been diagnosed by direct amniotic enzyme analysis or by staining uncultured fetal amni-

* Assistant Professor of Pediatrics and Medicine, Emory University School of Medicine. This work was supported by research grants from the USPHS: NIH AM 14771 and Clinical Research Center grant, RR-39. It was presented in part at the interim meeting of the Georgia State Obstetrical and Gynecological Society, May 13, 1971.

TABLE I
INBORN ERRORS DIAGNOSED BEFORE BIRTH

From Cultured Fibroblasts	
Disease	Technique
Pompe's	α -1, 4-glucosidase
Galactosemia	Gal-1-P-UDP transferase
X-Linked Hyperuricemia	HGPRT'ase
Lysosomal Acid Phosphatase	LAP'ase
Mucopolysaccharidosis	S ³⁵ O ₄ Uptake
Cystic Fibrosis	Metachromasia*
Marfan's Syndrome	Metachromasia*
Tay-Sachs	Hexosaminidase
Niemann-Pick	Sphingomyelinase
Gaucher's	Ceramide Glucosidase
Fabry's	Ceramide Galactosidase
Metachromatic Leukodystrophy	Arylsulfatase A
X-Linked Recessive	Karyotype
From Uncultured Cells or Amniotic Fluid	
Disease	Technique
Pompe's	Stain for α -1,4-glucosidase
Tay-Sachs	Isolation of Hexosaminidase
Mucopolysaccharidosis	Metachromatic stain
Methylmalonic Aciduria	Methylmalonate
Adrenogenital Syndrome	17 Ketosteroids and Pregnanetriol
From Maternal Urine	
Disease	Technique
Methylmalonic Aciduria	Methylmalonate
Adrenogenital Syndrome	Pregnanetriol

* Non-specific

otic cells. Methylmalonic aciduria and the adrenogenital syndrome have been diagnosed by finding excessive amniotic methylmalonate and 17 ketosteroid and pregnanetriol concentrations respectively. Although these latter two diagnoses required large amounts of fluid and were made only during the last trimester, this direct approach may be of more practical use in the future. The detection of disorders not expressed in fibroblasts such as phenylketonuria (PKU) may be made by quantitation of amniotic phenylalanine when better normal values for amniotic fluid amino acid concentrations are established at specific gestational periods. Finally, it is interesting that fetuses affected with methylmalonic aciduria and the adrenogenital syndrome produced an elevation in maternal urinary methylmalonate and 17 ketosteroids. Again, we do not know whether fetuses affected with PKU might express their defects in maternal urinary phenylalanine.

The latter questions are of more than research interest, since several diseases such as phenylketonuria, galactosemia, and Maple Syrup Urine disease are clearly preventable by dietary restriction. It should be noted at this point that most of the inborn errors listed in Table I were prevented through termination of pregnancy. However, because of early detection, dietary restriction prevented the sequelae of galactosemia and methylmalonic aciduria, and

replacement of cortisone prevented postnatal complications of the adrenogenital syndrome. These children were carried to term and treated before their metabolic diseases were manifest.

Antenatal Diagnosis

Although antenatal diagnosis may provide the maximum opportunity to prevent inherited metabolic disease from becoming manifest, this procedure is used primarily in specific enzyme defects where a positive family history and predictable "high risk" pregnancy are known. Most selective diagnostic screening for inherited metabolic disease is performed in the perinatal period. True non-selective screening is available only for phenylketonuria on a statewide basis. Georgia State law requires that all newborns have blood assayed using the Guthrie bacterial inhibition test for phenylalanine levels. If positive results are obtained, quantitative studies of phenylalanine conversion to tyrosine are necessary to confirm the diagnosis before instituting a phenylalanine restricted diet. Scriver and Gerald have clearly demonstrated that children affected with phenylalanine hydroxylase deficiency (classical PKU) must be treated appropriately before the *third week* of life to prevent mental retardation.⁶

Whether restricting maternal phenylalanine would prevent mental deficiency in a demonstrated fetus

with PKU remains speculative. PKU has an incidence of 1 in 10,000 and statewide screening procedures are economically feasible. Galactosemia is much rarer (1/35,000) and screening will be better affected through physicians with a high index of suspicion. In this disease, a mutant enzyme, galactose-1-P-uridyl transferase results in excessive accumulation of its precursor substrate, galactose-1-phosphate. This metabolite is toxic to liver, kidney, and brain and produces cirrhosis, a generalized Fanconi syndrome, cataracts, and mental deficiency if untreated. The disease was recently suspected in a 6-day-old boy with prolonged neonatal jaundice and hypoprothrombinemia. A urine was examined first by the child's physician and then through the Emory University Biochemical Genetics Laboratory (Table II) and found to have reducing substances which were not glucose. The child was immediately placed on a lactose-free diet. In subsequent studies 1,000 mg/day of urinary galactose excretions were quantitated and red blood cell assays confirmed the absence of galactose-1-P-uridyl transferase in the child and intermediate levels in both parents (Table III). The child's jaundice cleared on the lactose-free diet and he is now a normal four-month-old. Maternal milk restriction might have prevented the small cataracts which were present before perinatal treatment began. This simple maneuver should be performed in any pregnancy in which galactosemia is suspected.

TABLE II
URINARY BIOCHEMICAL SCREENING TESTS (D. DeC.)
ph = 5.0
Protein = 1+
Acetest = Neg
Copper Sulfate (Clinitest) = 4+
Glucose Oxidase (Glucostix) = Neg
Sugar Electrophoresis = only D-Galactose (approximately 1,000 mg%)
Amino Acid Electrophoresis = generalized increase in urinary amino acids
Interpretation: Galactosemia

Classic MSUD

In galactosemia, short delays between suspicion, diagnosis, and treatment may be reparable. In classic Maple Syrup Urine disease (MSUD), however, prenatal or perinatal diagnosis is imperative because severe neurologic deficits are irreversible once the disease is manifest. Two such families presented in the Atlanta area within the past 6 months. The

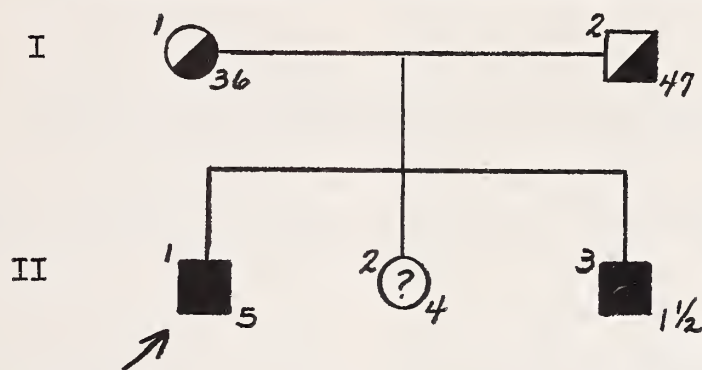
TABLE III			
GALACTOSEMIA: PEDIGREE DeC. RED BLOOD CELL ASSAY* (Galactose-1-P Uridyl Transferase and Galactokinase Activity)			
	UDPG Consumption (U/gm Hbg)	Fluorescent Transferase (U/gm Hbg)	Galactokinase Activity (mU/gm Hbg)
Patient	0.0	1.66	72.0
Mother	10.7	18.1	—
Father	13.1	22.8	—
Normal Range	(18.5-28.5)	(27.8-42.8)	(60-80)

* Assays were kindly performed by Dr. Ernest Beutler, Duarte, California.

TABLE IV
RESULTS OF URINARY SCREENING TESTS (PATIENT LB)
Smell: Fragrant, like maple syrup
Acetest: Trace
Reducing Substances: Negative
DNPH: Strongly Positive
FeCl ₃ : Positive (Grey-Green Reaction)
Amino Acid Electrophoresis: ↑↑↑ VAL, LEU, AND ISOLEU
Diagnosis: Maple Syrup Urine Disease

first child LB (Table IV) presented at 6 days of age with stupor and apnea following milk ingestion. Protein restriction was immediately instituted following the results of characteristic screening tests outlined in Table IV. Despite a biochemical response, she continued apneic and died. Her cultured skin fibroblasts expressed an absence of branched-chain keto acid decarboxylase. Since this enzyme function is present in normal skin and in fibroblasts cultured from amniotic fluid cells, subsequent pregnancies of these young parents can be monitored for MSUD. At least two alternatives are possible if an affected fetus were demonstrated. They could be offered pre- and perinatal dietary therapy or termination of pregnancy. Since we do not know what effects dietary therapy would have on this mutation, termination would be the safest way of assuring a normal family. The positive results of early therapy were quite dramatic in a second family affected with MSUD (Table V, Pedigree Car). Although two sons, now aged five and one and one half years respectively, had only 2-5 per cent normal branched-chain amino acid decarboxylating activity, the younger brother (II-3) was clinically normal while the older (II-1) was quadriplegic and severely retarded. Why? Because the older brother was not diagnosed and treated until age 7 weeks. The younger

TABLE V
MAPLE SYRUP URINE DISEASE
(Pedigree Car)



BRANCHED CHAIN AMINO ACID DECARBOXYLATION BY CULTURED FIBROBLASTS
(DPM C¹⁴O₂ formed/90 minutes/μgram protein)

Patient	L-Isoleucine-U-C ¹⁴	L-Leucine-1-C ¹⁴	L-Valine-1-C ¹⁴
Mother	66.4 (6)	118.4 (3)	83.7 (6)
Father	57.3 (6)	102.2 (3)	38.9 (9)
Proband (II-1)	2.3 (3)	5.9 (3)	2.6 (3)
Brother (II-3)	2.2 (3)	7.5 (3)	3.2 (3)
Normal	81.6 ± 6.1 (16)	101.0 ± 8.3 (20)	75.5 ± 8.3 (25)

Fibroblasts cultured from skin biopsies were harvested after 3 to 8 passages, washed, and suspended in buffer (pH 7.3) at 37°. C¹⁴ labelled branched chain amino acids were added and C¹⁴O₂ produced in 90 minutes was trapped in hyamine and counted by liquid scintillation spectrometry. The results were expressed as the mean ± 1 SD with the number of observations in parenthesis.

brother, on the other hand, was investigated at birth, defective enzyme activity determined, and branched-chain amino acid restriction instituted immediately by Dr. Selma Snyderman. Both brothers continue to live and their development is carefully controlled on this difficult and expensive diet. These clinical examples exemplify the benefits and pitfalls of our current embryonic application of perinatal diagnosis. The future will provide far better diagnostic and therapeutic approaches if support for research and the delivery of these new health care techniques continues.

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SEARLE RECEIVES CERTIFICATE OF APPRECIATION

The American College of Obstetricians & Gynecologists has presented a certificate of appreciation to G. D. Searle & Co., pharmaceutical manufacturer based in Skokie, Ill. Searle has had a medical exhibit at every annual meeting of ACOG, and helped support publication of the college's recently published history. The American College of Obstetricians & Gynecologists, founded in Chicago 20 years ago, was represented at the presentation by Donald F. Richardson, executive director. Accepting the certificate for Searle were William L. Searle, senior vice president, Domestic Pharmaceutical Division, and Donald A. Paul, medical meetings manager.

Presidential Remarks to the A.M.A.

PRESIDENT RICHARD M. NIXON, **Washington, D.C.*

DR. BORNEMEIER, all of the distinguished guests on the platform and all of the distinguished delegates to this convention:

I very much appreciated that reference by Dr. Bornemeier to the year 1966. Let me say he had a lot more confidence in my future than I had, I can assure you. I recall, too, the pleasure that I have had in addressing the AMA on another occasion in Atlantic City in 1951. Some of you will be old enough to remember that. I was then just a Senator. So this makes the third time that I have had the privilege to address this organization in their session.

I have also done a little checking with regard to when Presidents—at least that means Presidents of the United States—I understand all of these front rows are either presidents or past presidents of AMA—in checking the record I find that as far as Presidents of the United States are concerned, in the 120 years of this organization only four have had the privilege of addressing you. The last time was President Eisenhower in 1959. I am honored to be here as President, after having had the opportunity to address you as a Senator, as a former Vice President, and now as Chief Executive of the Nation.

Important Organization

It is very important that a President of the United States speak to this organization. The Presidents of the United States should, it seems to me, find more opportunities, perhaps, than four in 120 years to come before this organization for reasons that I will cover in my remarks today, because this is a very important organization.

I am referring to matters going far beyond the special competence, the technical competence, represented in such degree in this room. For example, just yesterday, as some of you may have noted in the press, my wife and I celebrated our 31st wed-

ding anniversary. It was a very inexpensive celebration. Normally we go out on such occasions. In this case we stayed in and watched television and watched a re-run of our daughter's wedding at the White House.

On that occasion, as I was thinking of that 31st wedding anniversary and putting together my remarks for today, I was reminded of a story which is probably very old to an organization of doctors, about a doctor who is celebrating one of his wedding anniversaries. He is trying to get out of the house for his weekly bridge game. He told his wife that he just had a call from a patient and he would have to leave. She said, "But, dear, is it serious? Is it important?" And he said, "Oh, it is very serious and very important. There are three doctors there already."

What that, of course, brings home to us is when you have any gathering of doctors, it is a very serious occasion and a very important occasion. So this gathering of thousands of doctors from all over America is important. It is important for reasons that I think, perhaps, we can find as we study the history of America and even further back than that.

Nation's Health

Disraeli once said that "the health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

That profound statement is one that we should consider today, and we should think of health in a much broader context than simply the physical health to which you have devoted your lives. I am happy for this opportunity to salute this profession which has contributed so much to the health of the American people and to the strength of this Nation.

America is a strong country. It is a good country. And one of the reasons it is a strong and a good country is because it is a healthy country, and we appreciate what you have done to make it a healthy country.

* Presented to the 120th Annual Session of the American Medical Association, June 22, 1971, Atlantic City, New Jersey.

You should take pride in those accomplishments—all Americans should. For we can never hope to repair any weaknesses that may exist in American medicine unless we fully appreciate its towering strengths.

One of the strengths of American medicine has always been that it has had a restless and inquiring spirit. All of you are aware of this. This spirit was summed up in a statement which the distinguished physician Charles Mayo made years ago about his equally distinguished brother, Will. He was "filled," said Charles, "with the genius of finding opportunities." The same point was made more recently by Dr. Jonas Salk when he said: "The greatest reward for doing is the opportunity to do more."

Health Opportunities

As we look at the current picture of health care in this country, we see many opportunities "for doing more." These opportunities have been recognized by this organization. You have spoken to them in your resolutions. You will be considering them in your meetings at this convention. Among them—the opportunities for doing more, problems to provide opportunities and their solutions—are these: There are too few doctors in some areas as you know, too many in others. We see a growing need for more health personnel, more efficient training. We have too many doctors spending too much time on routine tasks that others could help them with.

We recognize the growing menace of malpractice suits which force every doctor to look upon his patients as potential plaintiffs. As we look at American medicine we also see a need to place more emphasis on primary care, on preventive medicine, on outpatient treatment. And we see that despite our considerable progress in this area, in the field of voluntary health insurance, financial considerations still deny quality care to many Americans, while the dark threat of catastrophic costs still imperils most of our people. These are challenges. These are challenges that we can be grateful that our country now has entered into a period of productive discussion about the best way of meeting.

Welcome Debate

I say to this organization that I am sure many of you are concerned about what may come in the future in the reform of health care systems. But I say welcome this debate. You should join it. We need you to join it. We need your assistance in it. It will be a great debate. It will be a strong one. It will be one that will command the attention of the country in the weeks and months and perhaps for years ahead.

I noted with interest that your new president, Dr.

Hall, for several years has been the Boxing and Wrestling Commissioner of the State of Nevada. Well, you need a Boxing and Wrestling Commissioner in this debate that is coming in, I can assure you. For out of this time of discussion and decision will surely come a whole new era in the history of American health care.

Last February, I offered my own contributions to this discussion, a wide range of proposals that I have discussed with some of your leaders. These proposals are designed to balance growing demand for care with a growing supply of services. They are founded on the principle that we cannot simply buy our way to better medicine.

Damaging Plan

It is very easy sometimes to think that the plan that costs the most will help the most, but often the situation is just the opposite. In fact, I believe that the most expensive plan that has been offered in the current discussion on health care in America—a plan for nationalized compulsory health insurance—is the plan that would actually do the most to hurt American health care in this Nation.

This is not a new position for me. I made the same general statement in my speech in 1951 to this organization and in 1966. Let me give you the reasons why I have reached this conviction. The conviction is strongly held, as I am sure is the conviction held by those who advocate this plan.

First of all, if this plan went into operation, by fiscal year 1974 it would cost the Federal Government over \$77 billion. Let's bring it down to matters that all of us can better understand. It would drive the health share of the Federal budget to nearly 25 per cent. In other words, 25 per cent of the total Federal budget would be going for health care. And that would mean that we would be limiting our ability for handling other social problems.

Health Program Cost

Our present Federal health programs, if continued, would cost the average family in America an estimated \$405 per year by 1974. My plan would increase that cost, but increase it only to \$466 per year. Under the nationalized compulsory health insurance program, the average household's, the average family's American Federal tax bill for health programs alone would be tripled to \$1,271 a year.

Nationalized health insurance would exact a very high price from our people in terms of dollars and cents. These figures demonstrate that point. But, in my opinion, it would exact an even higher price, a price in terms of the quality of American medicine. On that score, let me just speak as a layman. When I am sick, I want to be able to get a doctor.

REMARKS / Nixon

But above everything else, I want a doctor who is a good doctor. I am interested in quality as well as the ability to provide for a doctor.

Federal Domination

When the Government pays all the bills for health care, then the Government becomes the only party with a strong interest in restraining costs. This inevitably means that Government officials would have to approve hospital budgets. They would have to set fee schedules. They would have to take other steps that would eventually lead to the complete Federal domination of our medical system. That is the road that some advocate. I think it is the wrong road.

Rather than freeing the doctor so that he can do more to help his patients, nationalized health insurance would burden him with the dead weight of more bureaucracy, more forms, more red tape. I know what kind of forms and red tape many of you have to fill out now.

Just let me again speak as a layman. When I go to a doctor, when I am sick, I want him to worry about me and not to be worrying about some form he has to fill out for the Government.

Rather than expanding the range of choice for doctors and patients, it would severely narrow that range. Rather than encouraging more responsibility at the local level, it would concentrate more responsibility in Washington. Rather than stimulating competition and diversity it would dull the incentive to experiment and innovate.

The Administration's Health Insurance Partnership would build on the strengths of the present health care system. Nationalized health insurance would tear that system apart.

America's health care system needs reform. You have recognized that. But we can never improve our country's medical system by working against our country's medical profession. Other nations that have gone down this road have found this out. No system of health care will ever work unless the doctors of the Nation make it work. We need your help make it work and to develop it. So let us work together for a system—a system that will continue to provide for choice, that will continue to provide for quality, and one that will at the same time deal with the pressing problems of costs in an effective way that will not destroy quality, a problem which all of us are deeply aware of.

Drug Abuse

I would like to talk to you today about another subject, a challenge in the health care field related to

it very directly, a problem which I note again you are taking up in your general sessions; in fact, this afternoon.

I refer to the problem of drug abuse. Drug abuse, I have said recently, is America's public enemy number one. It is the greatest of all present threats to our social future. We used to brush it off. We used to say it is a ghetto problem or it is a black problem, or it is a problem of the poor and the depressed and the wretched.

But today it is no longer just a ghetto problem. It is no longer just a problem that primarily affects those that are nonwhite or the poor, because its impact cuts across all social and economic lines in our country.

It has moved from the ghettos to the suburbs, from the poor to the upper middle class, and the upper class in terms of economic income. It afflicts the rich and the poor, the blacks and the white, the servicemen and the civilians, and the ghettos and the suburbs. It spreads like a plague throughout our society. It erodes our Nation's strength. It destroys our Nation's spirit. And, worst of all, it undermines our Nation's future.

I had a letter recently from a man who said that we are in danger of losing "a whole generation of Americans to drugs."

Two years ago I recommended a series of new laws to crack down on drug abuse, particularly in the enforcement field. Those laws passed the Congress last fall and they are beginning to prove their value. But more is needed, particularly in the field of rehabilitation.

Total Offensive

That is why I launched a totally new program for a total offensive nation-wide and to all segments of society against drug abuse.

The program I announced includes strong efforts to cut off the supply of dangerous narcotics at their sources in other countries. It more than doubles our budget for rehabilitation. It moves against drug abuse in the military. It sets up a new command post on drugs in the Executive Office of the President.

The President has many responsibilities. There are probably too many responsibilities that come to his desk. But this problem is so serious that I feel that the President must take personal command and personal responsibility. And that is what I have done.

New Office Head

That is why I have named as head of this new office in the White House one of the great experts in this field, a man—Dr. Jerome Jaffe—of great experi-

ence in Illinois. I think he represents the best of America's medical profession. He is tough. He is no nonsense. But he is also a man who is compassionate. He understands the problem. There is one assignment I have given, among many others. Believe it or not, there are nine Federal agencies that work in the field of drugs in the United States in drug abuse, and too often I have found, over the past two years, that those agencies are competing with each other for personnel, competing with each other for attention, competing with each other before Congressional committees for funds.

And I have given one instruction to Dr. Jaffe that I have ordered him to carry out without any question, and that is this: The Government agencies, the nine of them in this field, are going to quit fighting each other and start fighting the problem a little more.

Now, the offensive that I mentioned in drug abuse places new emphasis on education because that, of course, is the most important of all. We can stop the source of supply in one country and it moves to another. We can have stronger enforcement and people will go around it if the demand is great enough and if people are willing to pay. We can have rehabilitation but then that is probably too late if the problem goes that far.

Educational Need

So we need education—education as to the dangers of drug abuse. This is an area where human resources are going to make the difference. But the effectiveness of education depends on communication, on the trust that grows up between one human being and another. What is a good educator? Well, he must combine compassion with firmness, a sense of authority with a sense of sympathy, a capacity for discipline, a capacity for involvement.

I just described you. That is what doctors are. These are virtues you possess. They are values that you and your profession prize. And that is why I look to the medical profession, or all America looks to the medical profession, for leadership in this field of education in drug abuse.

Let me treat two aspects of the problem, one that is somewhat in your field. And if I step over the bounds of my own competence, I, of course, will expect you to correct me in any resolutions you adopt.

First of all, let me point to the link, and I believe that is a link, which exists between the inappropriate use of drugs within the medical context and the abuse of drugs outside that context. Consider these facts for a moment: In the last four years alone, the production and distribution of tranquilizers in our country has doubled. During 1970, 5 billion doses of tranquilizers, 3 billion doses of amphetamines

and 5 billion doses of barbiturates were produced in this country. Listen to this: The estimate is that 50 per cent of the amphetamines and barbiturates were diverted into illegal sales. So there is the problem in terms of education as well as enforcement.

Tranquilizers, amphetamines and barbiturates, as you know, are known as psychotropic or mind-altering drugs. It is estimated that one-third of all Americans between the ages of 18 and 74 used a psychotropic drug of some type last year. And little wonder—for there were enough drugs of this type available last year to medicate every adult in the United States at very high dosage rates for more than 11 days.

Drug Culture

Now, what does all this mean? What it means is that we have created in America a culture of drugs. We have produced an environment in which people come naturally to expect that they can take a pill for every problem—that they can find satisfaction and health and happiness in a handful of tablets or a few grains of powder.

We have to face up to the fact that within this climate it is altogether too easy for the abuse of drugs, not the prescription, now, and the use, but the abuse of drugs to flourish in that kind of climate, in a climate where individuals believe, because of inadequate education, that they can take a pill for every problem.

The medical profession was among the first to recognize this problem, to identify it as one of its causes, the fact that many physicians are prescribing drugs too often and too easily.

A number of the voices from your community have suggested recently that certain drugs may have become a crutch for some doctors as well as their patients, masking but not correcting more basic physical and emotional problems.

I noted with interest that your own Council on Drugs spoke to this subject only a few weeks ago. And I have noticed, too, that many doctors are now moving to strictly limit their prescription of such substances. I would hope, and I say this respectfully in an area where you are the experts and I am not, I hope you will continue to give careful consideration to this matter—for your role in shaping this country's basic attitude toward drugs will be decisive.

Asks Help

Let me turn now to a second way in which doctors can help. I want to ask your help, I ask the help of the doctors of this Nation in a program of education, educating our people in the proper role of drugs and drug information, drug counseling, drug treatment.

REMARKS / Nixon

Years ago, you remember that when most Americans lived in small towns we looked to the family doctor for guidance not just with regard to our physical health but in many other aspects of life. It may have been somewhat easier for many doctors to utilize their enormous potential as effective teachers in our society because of that situation that existed then.

I remember my own doctor, a family doctor, Dr. Thompson, of Whittier, California. He was a fine doctor but he was a community leader, and when he spoke on issues, we listened. When he came out to our school to speak on the problems of health and other related problems, we listened, we paid attention, we followed his advice. Some doctors still play this role today. You do it voluntarily. You contribute enormously of your time without compensation in educating America in these and other fields. But more doctors need to be playing it. We need you, especially in the field of drug education.

I have met recently in this field with the leaders of the Advertising Council, with the leaders of the television and radio industries, with the leaders of opinion-makers, editors, publishers and so forth throughout this country, and they have enlisted in this battle.

Figure of Authority

But no one, believe me, no one can have more effect when he or she speaks out than a doctor on this issue of drug abuse. You speak with greater authority, because you speak about the power of drugs to save life, and we must look to that, the tremendous progress that we have made in that field—but also the power to destroy it.

Rather than preach moralistically about the sinfulness of drugs, you can teach realistically about their physical and psychological impact, and you can bring tremendous credibility to this undertaking. Many doctors have been moving in that direction.

I noted, for example, that in Arizona, the Maricopa County Medical Society has pulled together an impressive drug control program for Phoenix, and I am happy to see that this Association has been actively encouraging such efforts. It has developed education materials to help local physicians as they go out to wage war against drugs in the schools and churches and neighborhoods of America.

We ask for a part of your time every day in this field if it can be effectively used.

Greater Effort

The time has come for a greater effort, and that is why I ask for your help and the help of this organization. I realize that you have engaged in many enterprises of this type for which the Nation is in your

debt. I know that one outstanding voluntary effort, the AMA Volunteer Physicians for Vietnam—and I have met several of your members who have gone to Vietnam, given of their time and effort—for the purpose of carrying out what is called a Project Vietnam, and its purpose is to improve medical care in that country for the people of that country. It has had very great success.

Now, as our attention begins to center again on domestic challenges, the AMA can once again render outstanding service at a point of critical need by helping to develop what I would like to call Project USA—a project which would marshal the tremendous energy, the brains, the dynamism, the leadership—the leadership—of the doctors of this country in an all-out battle against drug abuse. And against it in terms of educating particularly the young people of this country about it.

The best way to end drug abuse is to prevent it, and America's doctors are the indispensable front-line soldiers for success in this all important battle.

I began these remarks today by saying that the doctors of America have done a great deal for their country. But I also noted that the greatest reward for doing is the opportunity for doing more. There is much to be done in this Nation—in the fight against drugs, which I have covered, and in other areas.

Physician Leadership

And once again, Americans are looking to the doctors of their land for leadership. We are looking to the doctors of this land for leadership beyond the reform of our health care system in which you really provide leadership, and you should, because it affects you directly—beyond drug abuse, which is so closely related to your profession, where I am sure you will provide leadership.

America at this time needs leadership from those in the medical profession, and your wives, the AMA Auxiliary that I know is meeting here in Atlantic City with you—all across this country, not simply in the areas that affect you directly, but in the area of national problems.

I know many of you are so concerned whenever anybody suggests that you get into politics, and I do not speak in any partisan sense. I am not concerned about whether you are in politics in one party or the other. The main thing is to be in. I have heard a doctor say on occasion, "I am only interested in my profession; I am not interested in politics."

Let me tell you something: He better get interested in politics or he won't have any profession to be interested in.

And I am not referring just to politics to defend your profession. You should do that. Defend what is

best in it. Correct what needs to be corrected. But I am referring to politics in the broader sense of leadership.

Poor in Spirit

Let me put it in historical perspective. One hundred ninety years ago America was one of the weakest countries in the world, militarily, and one of the poorest countries in the world, economically. But it was a country that was rich in spirit, and thereby caught the imagination of the world and has held it ever since. Today America is the strongest nation in the world militarily, and the richest nation by far economically. The major problem we have to ask ourselves as Americans is: At a time when we are rich in goods and strong in arms, are we poor in spirit?

I don't think so. As I go across this land I am always reassured as I see so many Americans that have a deep conviction about the goodness of this country, who give of their time and their efforts to make it a better country, who are proud of what this Nation has done for its own people and what it has done in its leadership abroad. And yet, of course, there are other voices that are heard throughout the land, those that run America down, those that say our system is rotten, those that say America is an ugly country, those who say wouldn't it be well if some other nation were in a position of leadership and, therefore, following with the proposition that America withdraw onto itself and get away from the position of leadership in which it presently finds itself, with that leadership thrust upon it—not sought but thrust upon it—because of the accidents of history, the fact that in the free world there is no other nation rich enough or strong enough to assume that position of leadership.

What does all this have to do with doctors? Very simply this: In a community, a doctor is listened to. He is listened to about the health, of course, of his patients. But an individual can be physically healthy and he can be without health in a moral or spiritual sense, without character. A nation can be physically strong and unless it has moral character and stamina and faith in itself, and confidence, that nation is weak in a way that it cannot compensate with all the physical strength in the world.

So we go back to the early days of this Republic 190 years ago—weak, poor but strong in spirit, and here is America—rich, strong. Question: Are we weak in spirit?

And the answer, of course, would be found not simply in what a President says or a Senator—and we have some distinguished Senators here—or a Congressman or a Governor. But it comes from leaders throughout the country like yourselves.

You know that as far as this system has been run down so much around the world—when you go around the world to all the other countries they look to America, and the traffic, where there is traffic, is usually one-way. They are coming this way, they are not going the other way, when people have a choice.

Examine America

You know that this system of government that we have talked about and this economic system has its faults. There are too many poor people in America. There is too much discrimination and prejudice and all these other problems. But look at America's strengths. Look at the fact that there is more freedom, more opportunity, more income even for the poor because of the wealth of our country than there is in 85 per cent of the rest of the world.

So here we stand, looking at America. Examine its faults. Let us correct them. We need your help in your special field. But let us also recognize that in this particular period in this Nation's history—and this was not true 190 years ago—the health of America in this broader sense, not just physical but moral and spiritual and mental—that health will determine whether peace and freedom survives in the world.

We have no choice in the matter and if you ask yourself the question: If America does not have the role of world leadership, what other nation do you want to have it?

I should say the world can be fortunate that America, with its faults—and we have made many in foreign policy through our history—with its faults, let's look at the strengths: We have been in four wars in this century—World War I, World War II, Korea and now Vietnam. We have made our mistakes, but, to the great credit of America—and this can be said proudly and should be said by any American—Americans have fought and died not for an acre of territory, not to get domination over any other people, but for the right of other people to enjoy the freedom and the peace that we have, and this is something we must demand.

And so to the American Medical Association, representing tremendous competence, representing also leadership, the best educations that America can provide, I ask you today to join, to give a little more of your time than you have, not only in working for your profession—that must come first—but also in serving your country, providing the leadership that this country craves for in every community in the Nation.

The health of America is in your hands, and by its health I speak not just of its physical health—its mental health, its moral health, its character. Meet that challenge.

1600 Pennsylvania Avenue 20500

Committee on Maternal and Infant Welfare

LEGALLY PERFORMED ABORTIONS IN GEORGIA FROM NOVEMBER, 1969 TO AUGUST, 1970 AND SEPTEMBER, 1970 TO JUNE, 1971

	11/1/69 to 8/31/70	Percent	9/1/70 to 6/30/71	Percent
1. Number of abortion files received	339	100.0	1,060	100.0
2. Race:				
White	291	85.8	780	73.6
Black	46	13.6	278	26.2
Other	2	0.6	2	0.2
3. Age:				
<15	13	3.8	45	4.3
15-19	88	26.0	247	23.3
20-24	78	23.0	287	27.1
25-29	73	21.5	185	17.5
30-34	40	11.8	147	13.9
35-39	30	8.9	103	9.7
40-44	16	4.7	43	4.1
≥45	1	0.3	3	0.3
4. Weeks of Gestation:				
≤8	93	27.4	320	30.2
9-12	152	44.8	485	45.8
13-16	41	12.1	107	10.1
17-20	43	12.7	134	12.6
21-24	8	2.4	13	1.2
≥25	1	0.3	1	0.1
Unknown	1	0.3	0	—
5. Marital Status:				
Married	150	44.2	434	40.9
Single (including separated, widowed, divorced) ..	189	55.8	626	59.1
6. Number of Living Children:				
0	154	45.4	433	40.9
1 or 2	104	30.7	331	31.2
3 or more	81	23.9	292	27.5
Unknown	0	—	4	0.4
7. Reasons stated:				
Maternal Physical Health	40	11.8	121	11.4
Maternal Mental Health	264	77.9	512	48.3
Fetal Deformity	24	7.1	28	2.6
Rape or Incest	10	3.0	9	0.9
Contraceptive Failure	0	—	53	5.0
Social or Economic Hardship	1	0.3	315	29.7
Other	0	—	22	2.1
8. Procedure for Termination:				
Suction D & C	34	10.0	319	30.1
Surgical D & C	161	47.5	311	29.3
Saline Induction	47	13.9	141	13.3
Hysterotomy	21	6.2	29	2.7
Hysterectomy	20	5.9	73	6.9
Other	3	0.9	5	0.5
Unknown	53	15.6	181	17.1
9. Number of women reported to have had a voluntary sterilization at the same hospitalization	34	10.0	103	9.7
10. Number of hospitals reporting at least one abortion ..	24	—	36	—
11. Number of physicians performing at least one abor- tion	120	—	181	—

Source: Maternal Health Service, Georgia Department of Public Health, 8/11/71.

THIS IS NOT an accurate survey of abortions in Georgia. It is rather a simple tabulation of legally performed abortions in the state which allow the physician to compare like periods of time before and after recent court rulings.

This committee wishes to keep Georgia physicians informed of all developments in the abortion problem, feeling that such information will help them to make proper decisions in their own practices.

Copies of the required documents for each therapeutic abortion performed are filed with the Director of the State Department of Public Health in accordance with Section 26-1202 (b) (8) of the

Criminal Code of Georgia, Chapter 26-12. From the Fetal Death Certificate which accompanies this file, certain demographic and medical data is abstracted for statistical analysis.

Because of the significant increase in number of cases reported after the Federal District Court decision announced in August 1970, the following data is presented without comment or inferences. The 10 month period prior to the court decision is compared with a similar period after the announcement.

*Eugene L. Griffin, M.D., Chairman
MAG Committee on Maternal and
Infant Welfare*

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL AUGUST 8, 1971

Finance: Appropriated \$350.00 for an all-member mailing on the Association's Insurance Plans, \$150.00 for a full-page ad in the annual meeting program of the American Association of Medical Assistants, and \$100.00 for a mailing to announce the candidacy of J. Frank Walker, M.D., for Speaker of the AMA House of Delegates.

Appointments: New Liaison Committee with Composite State Board of Medical Examiners: W. C. Mitchell, F. G. Eldridge, Harrison L. Rogers, Jr., T. A. Sappington. Rural Health Committee: Glen Garrison and E. R. Hensley. Nominees to State Board of Health for State Clinical Lab, Blood Bank and Tissue Bank Committee: Hamil Murray, Gainesville; Lester Forbes and John T. Godwin, Atlanta. Talmadge Hospital Liaison: William D. Logan. Committee on Private Practice: W. Dan Jordan.

Headquarters Building: Terminated the feasibility study after a consultant's report indicating an over-

abundance of commercial office space in the area of the MAG building.

Separate State Department of Mental Health: Voted to oppose the separation.

AMA: Endorsed J. Frank Walker to run for Speaker of the AMA House of Delegates.

Membership Benefits: Abandoned efforts to market to the members a comprehensive Blue Cross-Blue Shield Plan and instead will negotiate for a plan with less benefits and a lower premium.

Medical College of Georgia: Adopted a resolution commending Drs. Harry B. O'Rear and Christopher C. Fordham, III.

Georgia Medical Care Foundation: Meetings scheduled for 11:00 a.m., Sunday, August 15, MAG Headquarters, and 2:00 p.m., Friday, September 17, The Cloister, Sea Island.

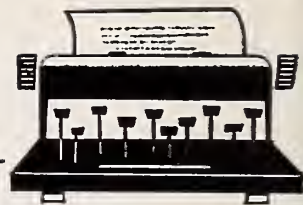
Next Meeting: 10:00 a.m., Saturday, September 18, 1971, The Cloister, Sea Island.

FLORIDA TO ISSUE MEDICAL LICENSES BY ENDORSEMENT

Effective September 1, 1971, for the first time in history, the Board of Medical Examiners of Florida may issue licenses by endorsement to practice medicine and surgery in Florida. An amendment to the Medical Practice Act of Florida, enacted by the 1971 legislature allows issuance of licenses by endorsement to those M.D.'s who have been certified by the National Board of Medical Examiners or the Federation Licensure Examination (FLEX) within a period of eight (8) years preceding the date of application for licensure by endorsement. Since the effective date is September 1, 1971, this means that an M.D. must have been certified by the National Board of Medical Examiners since September 1, 1963, in order to initially be eligible for licensure by endorsement. As far as other state licensure examinations are concerned, this

amendment only applies to those states who use the Federation Licensure Examination (FLEX) as their licensure examination.

In the case of foreign medical graduates, this does not eliminate the requirement that the M.D. have papers of first intention of citizenship and a minimum of one year's residency in the United States and the Educational Council for Foreign Medical Graduates Certificate of Proficiency. A very important feature of the amendment is the provision that a physician who receives a license by endorsement in Florida must practice in the state within a period of three years for a minimum period of one year. If he does not do this the license will become null and void. Service in the armed forces is exempt during these three years, but internship or residency time is not exempt.



Radiology Conferences Made Available

THIS MONTH marks the first presentation of a series of X-ray Conferences held at Grady Memorial Hospital and prepared by the Emory Department of Radiology. While numerous excellent clinical conferences have been published from the Medical College of Georgia, this is the first time that Radiology Conferences have been made available to readers of the *Journal*.

The frequent inclusion of such conferences in the *Journal* will depend on reader interest and comment. We would welcome any comment on these presentations.

Committee Conclave

THE FOURTH ANNUAL conclave of committees of the Medical Association of Georgia was held August 7-8, 1971, at the Sheraton Biltmore Hotel in Atlanta.

With 22 of the Association's 32 committees meeting during the two-day conference, the 1971-72 year had an excellent beginning. Numerous goals, plans for reaching same, and resolutions came from the committees. Some of the actions are recorded as follows:

Legislation

The Committee on National Legislation requested the appointment of a Speakers Bureau, and the Executive Committee authorized the Communications Committee to organize a Speakers Bureau in each District with a small number of people who could be asked to communicate with the public on health plans and new legislation. The Committee also urged members to staff the Doctor-of-the-Day Clinic at the special session of the General Assembly in the fall.

Education

The Task Force on Continuing Education voted to study the proposal for physician relicensure, based on evidence of continued education participation and possible retesting. The Regional Medical Program will be assisted by the Task Force on Clinical Facilities in determining funding for the development of area facilities. The Task Force on Medical Schools undertook the responsibility of planning the Education Conference, as well as investigating the development of a third medical school in the state. The Subcommittee on Nursing was assigned the duty of studying the curricula in the state's nursing schools, while the Subcommittee on Allied Health will examine training programs in the state and will work for the initiation or expansion of continuing education programs for allied health personnel. The Task Force on Medical Practice has been asked to study the "Educational Aspects of Peer Review" by the Executive Committee for a report at a later date.

Cancer

The Georgia Regional Medical Program requested that the MAG Cancer Committee assume program direction of various aspects of their cancer program. The Executive Committee gave authority to this Committee to assume the responsibility of program direction as requested by GRMP.

Peer Review

The following activities were reported: (1) Laboratory Proficiency Testing; (2) Educational Aspects of Peer Review—requested follow-up reports of decisions from the Committee on Education concerning legal counsel recommendations for disciplinary action; (3) Recommendations for frequency of nursing home visits by physicians; (4) Reimbursement for jejunioileostomy operations; and (5) Reimbursement for psychotherapy marathons. The Committee's specific goals are determination of policy decisions regarding the various aspects of Peer Review, including appropriateness of care and problems related to utilization of medical care.

Constitution and Bylaws

Several recommended changes came from this Committee, and will be reported to Council in September. They are the 1971 House of Delegates action to change wording to make the Treasurer an elected officer, and an Executive Committee request on membership classification, among others. The Committee on Constitution and Bylaws, upon investigation, found only one variation in MAG and AMA membership classifications and that is DE-3 Active (Dues Exempt)—retired from the active practice of medicine, for which the Committee recommended no change be made. Executive Committee approved this recommendation.

Maternal and Infant Welfare

In summary of the meeting, the Chairman stated that a careful evaluation of the Certificate of Live Birth and Death was being made; Abortion Legislation was discussed; a tabulation of legally performed abortions in Georgia was studied and a decision made to publish this data in the *Journal*, and approval was given to support HB 1044 to establish a Council on Maternal Health.

Headquarters Expansion Feasibility Study

Dr. Eldridge reported that a meeting of the Committee with the architects had been held. The Headquarters Expansion Committee recommends waiting until November, when the MARTA referendum is held, in order to estimate outside rental and other aspects, as the Headquarters Building is situated in close proximity to a proposed station. On motion the Executive Committee approved this recommendation.

Mental Health

The Mental Health Committee approved the legislation to be introduced regarding hypnotists, without inclusion of other paramedical personnel. It voted to reaffirm the MAG position of 1966 that the Division of Mental Health remain under the Department of Health, and further recommended that the Director of the Division of Mental Health needs the advantage of close personal communication with the Governor and requested that the State Board of Health promote such relations to the fullest extent possible. The Committee opposed any other reorganization which would result in another administrative level and lessen communication between the Director of the Department of Health and the Governor. The Committee also recommended that Executive Committee request the Governor to place the newly developed narcotics treatment program which is now operating at the direction of the Governor, under the direction of the Department of Health. Executive Committee voted to write the Governor to retain the Division of Mental Health under the Department of Health, and ask that the Department of Health be allowed to direct the drug program in the state. It was suggested that Mr. John Moore be informed of this action with a further report to Council in September.

Emergency Medical Services

The Committee's activities were reviewed as follows: (1) Proposal to Governor regarding formation of Governor's Commission on Emergency Medical Services

at present being considered; (2) Ambulance Legislation: As proposed legislation was returned to committee in 1971 legislative session, the Committee requested the Executive Committee to designate this Ambulance bill a top priority legislative effort and to make staff services available to help with support of its passage; (3) A guide for mass casualty planning for any size hospital has been prepared by the Committee and reprints will be made available for distribution to hospitals and planners when published; (4) Placing of signs on state highways indicating locations of hospitals and map indications of hospital locations is being supported; (5) The role of the Committee in teaching and evaluating students in Emergency Medical Technicians-Ambulance courses was discussed; (6) Processing of emergency service projects for state support; (7) Discussed categories of Hospital Emergency Departments; (8) Will urge FCC to establish emergency frequencies for hospital and ambulance use; (9) Support Georgia Conservancy in concept of recycling disposable glass; (10) Discussed efforts being made to obtain helicopter evacuation service for more rural areas in the state. With regard to the Ambulance Bill, the Executive Committee voted to continue support.

AMA Speaker of the House of Delegates

It was announced that Dr. Russell Roth, presently Speaker of the AMA House of Delegates, will be nominated for President-Elect. As Dr. Frank Walker is now Vice Speaker, the Executive Committee recommended that an announcement by MAG that Dr. Walker would run as Speaker of the House be made immediately. They approved the appropriation of \$100 from the Executive Committee discretionary fund for this purpose in the form of a mailing to the AMA Delegates.

Insurance and Economics

The Insurance and Economics Committee recommended to Executive Committee for approval the following three items:

1. That the Comprehensive Blue Cross-Blue Shield Plan offered to members will be abandoned in favor of an alternative plan offering a Blue Cross \$50.00 deductible contract with optional Blue Shield, optional maternity benefits, and an alternative plan for those over 65.

2. That the American Medical Association has instituted a plan for underwriting seven state professional liability programs through a national brokerage firm which will not affect the favorable plan available to Georgia physicians through the Medical Association of Georgia-St. Paul Insurance Company program.

3. An explanation of recent national action affecting catastrophic umbrella liability plans resulting in an increase in premiums to those Georgia physicians carrying the Top Brass St. Paul policy.

The Executive Committee approved an appropriation of \$350.00 from their discretionary fund for a mailing containing the above information, with the MAG staff attempting to obtain some of this cost from the St. Paul Company.

Occupational Health

A discussion of recent changes in the Workmen's Compensation Law, primarily concerned with increase in medical payments toward "unlimited medical" occupied the Committee's time at this meeting. The Committee will continue to assist industry in understanding and implementing the Occupational Safety and Health Act of 1970, and assisting the state in re-evaluating the Occupational Health Act. The chairman of the Committee reminded Executive Committee that the fee schedule is now on a usual and customary basis with the peer review being handled by the Foundation. He urged better surveillance of the usual and customary fees and asked that the Georgia Medical Care Foundation Board be asked to consider this.



THE DOCTOR'S WIFE

I HAD THE PLEASURE of serving as chairman of the committee to the Medical Auxiliary from 1967 to 1970. I was told it was like throwing Daniel into the lion's den, but I have always been fond of doctors' wives (I have one of my own), so I carried on, unafraid, and enjoyed every minute of it. Since that time I have always wanted to dedicate an article to "The Doctor's Wife," mine in particular, and to the women's auxiliary as a group. So lend an ear to my thing.

I have always thought doctors' wives stood head and shoulders above the common herd—thoroughbreds, if you prefer. Theirs is a difficult and unheralded life's work. To tolerate doctors, much less marry one, they would have to be missing some of their marbles, or else they had to be strong, courageous, and endowed with a good sense of humor. It is a credit to the medical profession that their wives usually respect, admire and love their husbands. The practice of medicine, being a hard task master, develops the best in human character and favorably affects all who are encompassed by it. That is why the wives are so enthusiastic about the profession, even though the doctors are often hard to live with. They know their husbands are hard to live with because they are dedicated to their profession and that the welfare of their patients gets top priority, and for this reason doctors are not good team mates except in medical undertakings. The life of a doctor's wife has taught them to take it on the chin with a smile and they hold little respect for anyone who does otherwise. It is self-evident that the doctor's wife is intelligent, of sound integrity, has good judgment, deep understanding, sympathy, a never-failing tactfulness, and the ability to keep her mouth shut, even in her own home. She is actually an adopted member of the medical profession and must therefore live up to its ethics and ideals.

The doctor's wife is that rare person who can remain anonymous, be the power behind the throne and never let even the king suspect it. She reaches the ultimate in unselfishness by giving without thought of reward or recognition and whose only reward is to be allowed to serve humanity in the most humble and trying capacity—that of being a doctor's wife. Being filled with loyalty, courage, and kindness, it would be unlikely for her to indulge in self pity, suspicion, envy, or jealousy. (My own wife says she has never been jealous of me because I am too nice, too much of a gentleman, and besides, I'm too old.)

I could go on and on, but in conclusion I would like to express to you doctors' wives, in the name of the entire medical profession, the affection, admiration, and gratitude which all of us feel for you, the Handmaidens of Medicine—The Doctor's

Acolytes. We humbly acknowledge a debt which we can never repay. We grant our many failings as husbands and, realizing that we will seldom correct these failings, we throw ourselves on your mercy and love. And that's the truth.

To any of you doctors who have had a hard time telling your wives what you thought of them lately, show them this and at least say this is also the way you feel toward *your* tender gender. I don't believe it'll cause you to get your head bashed in.

See you next month.

W. C. Mitchell

W. C. Mitchell, M.D.
President, Medical Association of Ga.

FOUR GEORGIA SCIENTISTS AWARDED RESEARCH GRANTS IN \$15 MILLION PROGRAM

Four Georgia scientists were named by the American Heart Association to receive research grants during the 1971-72 fiscal year, Dan Burge, M.D., President of the Georgia Heart Association, has announced.

Following are grants made in Georgia by the American Heart Association:

Sheldon N. Skinner, M.D., Emory University (Specific Tissue Blood Flow During Coronary Occlusion); Mario Digirolamo, M.D., Emory University School of Medicine (Fat Cell Size, Blood Flow and Metabolic Capacities).

Armand M. Karow, Jr., Ph.D., Medical College of Georgia (Factors Influencing Cell Survival After Freezing); Nancy C. Flowers, M.D., Medical College

of Georgia (Alteration of Myocardial Recovery—Index to Ischemia).

With the newly announced Grants-in-Aid, more than \$15 million—a record amount—will be expended on research by the American Heart Association and its affiliates in the next fiscal period, Burge said. The Association's research program is supported entirely by public contributions to the Heart Fund campaign in February.

Of the \$15 million total, more than \$6.5 million represent allocations made this year by the Association's national Research Committee. The \$8.5 million balance will be expended by state and local Heart Associations for their own research programs.

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SINOATRIAL BLOCK

PAUL WALTER, M.D., *Atlanta*

SINOATRIAL (SA) block has been considered a rare and transient disturbance of cardiac rhythm, seldom giving rise to symptoms. It is usually due to increased vagal discharge or to digitalis. Quinidine, hyperkalemia, ischemia and acute infections are among other reported causes of SA block. SA block is partial or complete interference with the propagation of impulses from the sinus node to the atrium. If one or more impulses fails to emerge from the SA node, second degree SA block exists. The electrocardiogram will show the absence of an expected sinus P wave. Second-degree SA block must be differentiated from non-conducted atrial premature beats and sinus arrhythmia.

SA block is not invariably benign. In 1954 the syndrome of syncope associated with alternating bradycardia and supraventricular tachycardia was first described. Subsequently, a symptom complex has emerged, known variously as the bradycardia-tachycardia, sick sinus, or sluggish sinus node syndrome. It is characterized by syncope due to SA block and sinus bradycardia associated with a complete spectrum of paroxysmal supraventricular tachycardias.

SA block occurs primarily in the elderly. ECG evidence of sinus bradycardia or SA block may be present for months to years prior to the onset of symptoms. SA block does not ordinarily produce symptoms unless there is an associated depression of lower pacemakers. Normally, a patient is protected against syncope by the discharge of a A-V junctional escape pacemaker at 40-60 times per minute. In the bradycardia-tachycardia syndrome however, failure of subsidiary pacemakers allows for heart rates of less than 40/minute and periods of asystole lasting several seconds or longer. Another characteristic feature, noted in at least 50 per cent of reported cases, is the high frequency of paroxysmal supraventricular tachycardias. The most common of these is atrial fibrillation or flutter. The genesis of the tachycardias may be related to the slow atrial rate, a situation analogous to ventricular arrhythmias with complete AV block.

Symptoms

Syncope is the most common and serious symptom, but angina pectoris and congestive heart failure may be aggravated by the rhythm disturbances. Syncope occurs by two major mechanisms: First, further slowing of a sinus bradycardia and an increase in the degree of SA block may result in a several-second period of undetectable sinus activity (sinus arrest). Second, there may be a prolonged period of asystole at the cessation of a supraventricular tachycardia. An occasional patient will experience syncope at the onset of a rapid tachycardia.

The chronic nature of the SA block makes it likely that organic lesions within and around the sinus node and distal conducting system are the underlying causes, but there is insufficient pathologic data to substantiate or refute this hypothesis. As the conducting system may be involved by many pathological processes, the etiology of this syndrome is not well defined. In New York, Moss & Kramer in 1970 found a relatively high incidence of right rather than left coronary atherosclerosis by coronary arteriography. In a number of cases, no associated heart disease can be found.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

The most frequent indication for therapy is a syncopal attack. Drug therapy has been ineffective and occasionally dangerous. Attempts to suppress the tachyarrhythmias with digitalis, quinidine and propranolol are rarely successful. These drugs may increase the risk of syncope, possibly by further suppression of subsidiary pacemakers. Conversely, a trial of vagolytic agents to accelerate a bradyarrhythmia is generally unsuccessful. The most effective treatment is the use of a permanent ventricular pacemaker, preferably of the demand type. Permanent ventricular pacing will prevent the bradycardia and allow the use of antiarrhythmic drugs without fear of dangerous rate suppression. Occasionally, pacemaker therapy alone will abolish the tachyarrhythmias, but more commonly antiarrhythmic drugs are required in addition to the pacemaker. Although permanent atrial pacing has been tried, transvenous ventricular pacing is preferable because it is technically easier and because a number of patients with SA block also have overt or latent abnormalities of AV conduction.

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THE ASSOCIATION

PERSONALS

First District

Leon E. Curry of Metter has been re-elected to active membership in the American Academy of General Practice.

Fourth District

Henry Calvin Jackson of Manchester has been re-elected to active membership in the American Academy of General Practice.

Fifth District

Ernest A. Dunbar, Jr., of Forest Park, has been named a Fellow of the American Academy of Pediatrics.

Alfred A. Messer, Atlanta, presented a paper in July at the International Congress on Applied Psychology, held in Liege, Belgium. His presentation was entitled, "Fatal One-Car Crashes: Accident or Suicide?"

Sixth District

Jaime Franco of Dublin has entered into partnership with **Wallace Lucas** for the practice of medicine.

Walter Jones Revell of Louisville has been re-elected to active membership in the American Academy of General Practice.

DEATHS

David F. James

David F. James, 56, an internal medicine diagnostician and a professor of internal medicine at Emory University Medical School, died July 26 at his home in Atlanta.

Dr. James was born in Washington, D.C., and was a graduate of Catholic University and Georgetown University School of Medicine. He was one of the founders of the Emory Clinic and was a staff member of Grady, St. Joseph's, Crawford Long and Emory University hospitals. He was a veteran of World War II.

He is survived by his widow, two daughters and a son.

Aloysius I. Miller

Aloysius I. Miller, a Marietta psychiatrist, died July 15 at his home in Atlanta. He was 44 years old.

Dr. Miller was born in New York, received his B.A. degree from Buffalo University, Ph.D. and M.D. degrees from Emory University School of Medicine. He served as a lieutenant in the medical corps of the U.S. Navy during World War II and the Korean War.

Senior Consultant to the Center for Interpersonal Studies at Brawner Hospital in Smyrna, he was formerly director of medical research at Georgetown

University Medical School and past vice president of the Atlanta Clinical Society.

At the time of his death, Dr. Miller was president of the Georgia Psychiatric Association and a member of Our Lady of the Assumption Catholic Church in Atlanta.

Dr. Miller is survived by his widow, the former Dorothy Wulfers; four sons, Mark, Chris, Aloysius III and Michael Miller of Atlanta; mother, Mrs. Albert F. Miller of Atlanta, and sister, Mrs. John Ostrowski of Pittsburgh, Pa.

Ernest Thompson

Ernest Thompson, who had served 14 years as district medical director of what is now the Metro West District, died July 14 in Marietta of an apparent heart attack.

A native of Winston, Ga., Dr. Thompson was graduated from Emory University Medical School and the University of North Carolina School of Public Health.

He was a member of Phi Beta Pi medical fraternity and the American, Georgia, and Cobb County Medical organizations. He belonged to the American and Georgia Public Health Physicians' organizations.

Dr. Thompson also was a member of the Marietta Kiwanis, the Masonic Lodge of Monroe and was a deacon in the First Baptist Church of Marietta.

He is survived by his widow, Mrs. Gladys Taylor Thompson; one son, Michael T. Thompson, of Powder Springs; his mother, Mrs. A. O. Thompson of Villa Rica; sister, Mrs. Lyn C. Baldwin of Decatur, and two grandchildren, Lisa and Melissa Thompson of Powder Springs.

PHARMACIST COMPLIANCE WITH CONTROLLED SUBSTANCES ACT

Pharmacists are facing, along with physicians, the responsibility for complying with the provisions of the Controlled Substances Act. The pharmacists have asked for our understanding in this Federal Law placing new requirements on both professions.

Under the Act, pharmacists are required to report to the Bureau of Narcotics and Dangerous Drugs any instance where they do not receive within 72 hours a written prescription for a controlled substance to substantiate orders for prescriptions accepted over the telephone. Both pharmacists and physicians are subject to penalties for non-compliance of this requirement, including possible rescinding of a physician's BNDD registration and his privileges of prescribing substances controlled by the Act.

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Airborne
Allergens in Georgia
see page 329



Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.^{1,2}

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

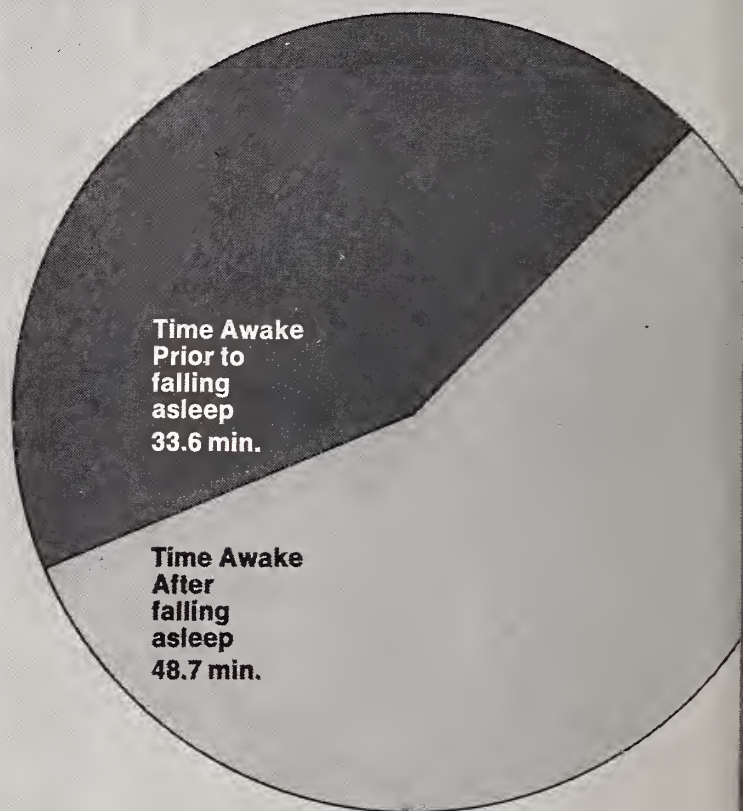
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

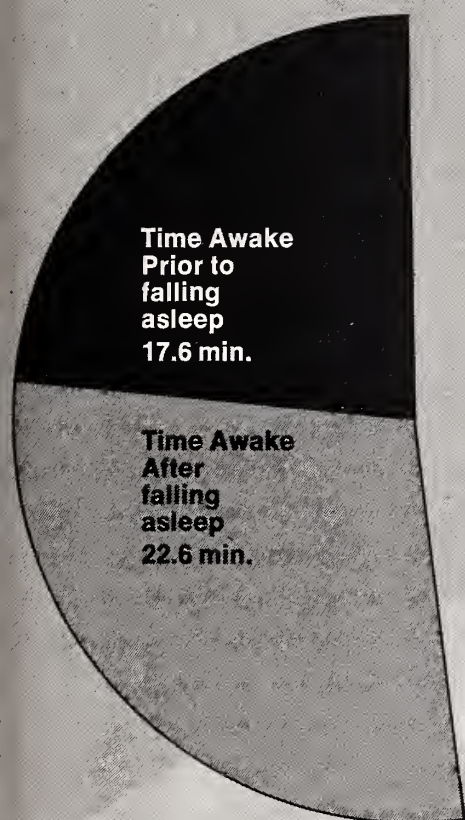
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

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(flurazepam HCl)



and slept through the night

On
Dalmane
(flurazepam HCl)



Age sleep laboratory measurements in cited studies

Parameter	Before Dalmane	On Dalmane
Time required to fall asleep	33.6 min.	17.6 min.
Time after onset of sleep	48.7 min.	22.6 min.
Number of wakeful periods after onset of sleep	12.2	8.4
Total sleep time	420.0 min.	447.5 min.
Percent sleep	88.6	94.5

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Cover

The cover shows plants common to Georgia and the Southeast and the pollen (magnified 5,000 times) they produce. The plants, from left to right, are the privet hedge, wormwood, ragweed, timothy grass, English plantain, and Russian thistle. Cover by Robert Hamill, Atlanta.

A useful general guide to the seasonal variations of airborne allergens in Georgia.

Airborne Allergens

BETTY B. WRAY, M.D., and BETTY D. GRAY, M.S., Augusta

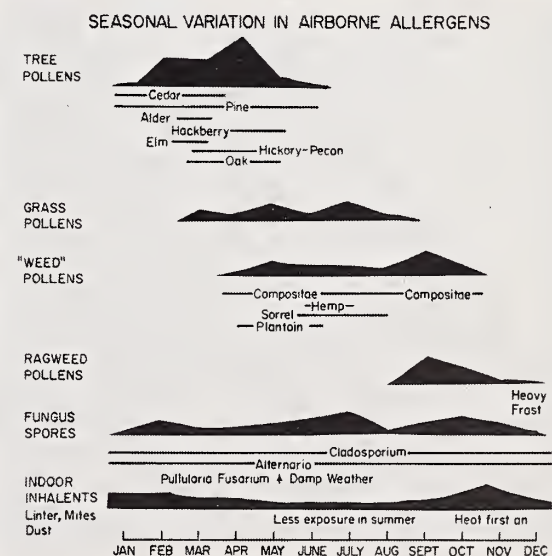
MAN HAS LONG BEEN AWARE of the effects of changing seasons and weather on certain of his ills, but only during the last century has specific sensitivity to certain airborne pollens and mold spores been recognized. At least 10 per cent of the population develop immediate allergic reactivity and are significantly bothered at one time or another by the prevailing aeroallergens. Respiratory symptoms are most common, although other organ systems such as the skin and the gastrointestinal tract may be involved.

Knowledge of seasonal trends of airborne pollens and fungus spores in his geographical area will enable the physician to better clarify etiology in many cases of hay fever and/or asthma. In addition, the recurrence of respiratory tract symptoms such as sinusitis and bronchitis in a seasonal pattern may suggest an allergic factor not previously recognized. However, sensitivity to multiple inhalants (and sometimes foods) may obscure this periodicity and produce year-round symptoms. In such instances, recourse to home environmental surveys, food histories, and allergy skin testing may be necessary to delineate the etiologic allergens.

The chart which follows is presented as a general guide to the seasonal variations of airborne allergens in Georgia. It is based on volumetric sampling carried out in Augusta over the past two years. Augusta is located on the fall line between the Piedmont and Coastal Plains Regions of Georgia, accounting for the wide variations in vegetation exhibited by our pollen counts.

The pollens show definite seasonal patterns with only minor variations from year to year. However, the fungal spores do not occur in definite seasons although some such as *Alternaria* usually show seasonal peaks. Some fungal spores appear only in

damp, rainy weather. Nine genera were found repeatedly every month throughout the year. The air is never free of fungus spores!



During cold months the patient receives greater exposure to indoor inhalants such as dust, feathers, animal hair, cotton linter, and tobacco smoke. Recently mites have been recognized in bedding and upholstery wherever people live, and are considered a major indoor allergen.

With the pattern of symptoms in mind, the physician can recommend avoidance measures and symptomatic medication. Only if these measures fail will it be necessary for the patient to receive more elaborate studies and management. Educating the allergic patient or parent regarding these potential troublemakers in his environment is one of the most important services a physician can provide. Common sense will hopefully then allow the patient to recognize and avoid many of his allergens.

Medical College of Georgia 30902

Correction of Deafness

J. A. CARTER, M.D., *Atlanta*

THE ELDERLY PATIENT who strains to hear, saying, "what?" to our queries is a familiar source of frustration to physician and family alike. The magnitude of the problem may be seen from public health surveys which have shown that 1 per cent of the population had a severe handicap as evidenced by a loss of 45 decibels or more.¹ Many patients are reluctant to consult physicians about hearing loss because they are embarrassed to use a hearing aid and are unaware that new ways of correction of deafness came into being in the 60's. Certain innovations of the past two decades have made surgery of deafness practical. These include better understanding of the anatomy, physiology and acoustical characteristics of the ear, the introduction of the operating microscope, and antibiotics. The development of tympanic membrane grafting and the use of prosthetics have also contributed greatly. This paper will be limited to techniques for correction of deafness which comprise only a part of the field of otologic surgery and discussion of Bell's palsy, Meniere's disease and eighth nerve tumors is omitted.

Types of Hearing Loss

Hearing losses are of two types, conductive and sensorineural. Conductive loss results from any defect in the transmission of sound waves to the inner ear. This defect may occur at the level of the external canal, the drumhead (tympanic membrane), the middle ear space, the ossicles (malleus, incus, or stapes) or the oval window. These problems are amenable to correction and are the ones to be discussed in detail.

Sensorineural loss is caused by a lesion of the inner ear (the cochlea, the acoustic nerve or the central neural pathways). Hearing aids and lip reading are the only means of relieving the disability of sensorineural hearing loss.

The two types of hearing loss must be differentiated. While the precise evaluation of hearing loss requires an audiometer, sound isolation, and a qualified tester, a screening test may be easily performed with the tuning fork. The patient compares the loud-

ness of the 512 Hz fork held beside the ear (air conduction) with that when the fork is pressed against the mastoid bone (bone conduction). If the sound is heard louder or longer by bone conduction (a "negative" Rinne test), then a conductive loss is presumed. For normal hearing or cases of sensorineural loss, the air conducted sound will be greater (a "positive" Rinne test). Conductive hearing losses are usually accompanied by good speech discrimination (the ability to discern accurately the phonetic elements of speech).

The decision as to the advisability of surgery will ultimately depend upon the otologist's history, examination, and interpretation of the audiogram and x-rays of the ear. The objectives are to restore to normal or improve the sound transmission to the inner ear. The causes for hearing loss which can be corrected are congenital anomalies, acquired lesions of the external canal, trauma, serous otitis media, chronic suppurative otitis media, and otosclerosis.

Congenital Anomalies

The external ear and middle ear structures are derived embryologically from the first and second branchial arches, while the inner ear develops from a different area called the otic placode. As a consequence, anomalies of the auricle, external canal, and middle ear usually accompany one another without affecting the inner ear.

Early detection of hearing loss before age one year ideally is important so that the child may be fitted with amplification during the formative years.² When the child is four or five years of age, the feasibility of surgical correction can be evaluated. This applies to cases of bilateral hearing loss. Unilateral problems are best delayed until age 15 or 16 and are not a serious handicap.

Lesions of the External Canal

Acquired lesions of the external canal, severe enough to cause hearing loss, are rare but range from complete occlusion with cerumen to exostoses of the bony canal and stenosis from infection. These

conditions are treated accordingly with removal or widening of the canal and sometimes skin grafting to prevent recurrent stenosis.

Traumatic Lesions

Traumatic lesions may involve blast injuries, penetrating foreign bodies, or temporal bone fractures. Perforations of the eardrum resulting from trauma usually heal spontaneously; however, disruption of the ossicular chain requires surgical intervention. This can be done by a transcanal approach under local or general anesthesia. Defects are corrected by interposition of autogenous bone, cartilage or prosthetics.

Severe vertigo accompanying an injury indicates fistulization of the inner ear, usually due to subluxation of the stapes. Immediate surgical intervention is indicated to prevent profound sensorineural hearing loss.³

Temporal bone fractures are of two types: transverse, resulting in complete loss of hearing and facial palsy; and longitudinal, resulting in varying degrees of conductive or sensorineural losses, depending upon the location of the fracture. Fractures are usually treated with antibiotics. Surgical exploration is indicated only when accompanied by a facial palsy of immediate onset and only when the patient's condition permits. Residual conductive losses can also be corrected at a later date.

Seromucinous Otitis Media

Seromucinous otitis media is the most common cause of chronic conductive hearing loss in childhood. The cause appears to be primarily failure of Eustachian tube function.⁴ Primary treatment is directed toward improving Eustachian tube patency by Politzerization, correction of allergic factors, removal of hypertrophied adenoids, and myringotomy. If these fail, a pressure equalizing tube can be inserted through an incision in the eardrum to ventilate the middle ear. The hearing is restored to normal; the tube is spontaneously extruded in two to four months; and the hole in the eardrum heals promptly.

Chronic Otitis Media

The simple mastoidectomy and the radical mastoidectomy are not performed as frequently as they were in the preantibiotic era, although each still has a place. With the advent of antibiotics and the operating microscope, it is now possible to arrest chronic infection and perform reconstructive procedures to preserve or improve hearing. Thus we enter the era of tympanoplastic surgery. The goals of tympanoplasty are to make an ear safe, stop discharge, and improve hearing. Some discharging ears will respond

to medical therapy; certain discharging ears do not respond to medical treatment but are safe and do not always require surgery. Two types of pathological change that demand surgery to eliminate risk of serious complication (brain abscess, meningitis, facial palsy, and profound deafness) are progressive, rarefying osteitis and cholesteatoma.

Reconstructive procedures for chronic suppurative ear disease range from myringoplasty, which is the closure of a tympanic membrane perforation, to an extensive mastoidectomy and reconstruction of a new drumhead and middle ear sound transmission mechanism.

An effective middle ear mechanism transmits the sound from the environment to the inner ear. Normally 99 per cent of sound energy is reflected at the interface between air and fluid. The middle ear circumvents this problem by acting as a transducer. The tympanic membrane is much larger in cross sectional area than the oval window; and the ossicular chain acts as a lever mechanism. The combination of the lever action and the ratio between drumhead and oval window result in a mechanical advantage of about 21. For simplicity, one can think of the transmitted sound as magnified 21 times.

Tympanoplasty strives to preserve or reconstruct the middle ear structures. Perforations of the drumhead are repaired, or a new drumhead is fashioned. Fascia from the temporalis muscle is the material preferred by most surgeons. Ossicular discontinuity may be corrected by transposition of ossicular remnants, prosthetics, and bone or cartilage grafts.

Not to be outdone by heart and kidney surgeons, some otologists have developed so-called "ear transplants."⁵ Actually what is transplanted is a cadaver homograft of tympanic membrane and ossicles. At present, the procedure has no advantage over temporalis fascia grafts since the transplanted ossicles do not function as levers to obtain a mechanical advantage as in normal middle ears.

Otosclerosis

Otosclerosis is a disorder of the labyrinth in which an overgrowth of spongy bone fixes the stapes footplate, resulting in conductive hearing loss. It causes hearing loss in about 1.2 per cent of the adult white population. It develops in early adult life, usually bilaterally and is frequently associated with a family history of hearing loss.

The first, moderately successful operation for otosclerosis was the fenestration. However, it resulted in a troublesome mastoid cavity requiring cleaning and a residual 25-30 decibel deficit. The stapes mobilization soon followed, but the improvement was usually temporary. The stapedectomy is now the operation of choice.⁶ Under local anesthesia

and the operating microscope, the drumhead is reflected. The stapes and its footplate are removed using tiny hooks and picks; and then a prosthesis of stainless steel wire and gelfoam or fat occludes the oval window and is attached to the long process of the incus. Stapedectomy is successful in restoring normal hearing in over 90 per cent of the cases, is performed under local anesthesia so that age and general health are not contraindications, and is free of pain and most of the dizziness which characterized the older fenestration procedures. The patients usually go home after the second postoperative day and can return to work after one week.

Summary

An attempt has been made to review for the non-otologist the types of hearing loss and the ways of differentiating them. The etiologic factors have been divided into the following groups: congenital anom-

alies, external canal lesions, trauma, serous otitis, chronic suppurative otitis media, and otosclerosis. A brief description of the procedures utilized by modern otologists for the relief of hearing loss follows each category.

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ABFP SCHEDULES EXAM

The American Board of Family Practice announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two-day period on April 29-30, 1972. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

PLEASE NOTE: Deadline for receiving completed applications in the Board office is February 1, 1972.

SOUTHERN MEDICAL ASSOCIATION MEETING

Plans have been completed for the 65th annual meeting of the Southern Medical Association, the largest regional medical association and second largest general medical association in the country. To be held October 31 through November 4, 1971, at the Fontainebleau Hotel in Miami Beach, Fla., this meeting is expected to be one of the most outstanding ever held by the Southern Medical Association.

Dr. Merlin K. DuVal, Jr., new H.E.W. assistant secretary for health and science, will be guest speaker at

the President's Luncheon on Tuesday, November 2. Other speakers include Congressman Joel T. Broyhill of Virginia, one of the primary sponsors of the present national health and insurance bills before Congress, and Dr. Carl A. Hoffman, Huntington, West Virginia, president-elect of the American Medical Association. Numerous social events are also scheduled in conjunction with the meeting.

There is no registration fee, and all physicians and their wives are invited to attend.

*A description of some pilot programs
within the state, pointing toward more
efficient utilization of nursing skills
in the health care team.*

The Extended Role of the Public Health Nurse in Child Health Care in Georgia

MISS JUDY LORD, R.N., M.N.,* *Atlanta*

THROUGHOUT THE NATION different methods are being conceived to meet the health needs of children. Programs preparing pediatric nurse practitioners, pediatric assistants, pediatric associates and others for roles in health care are now in existence. The programs vary in length with some requiring a nursing background and others requiring only a high school diploma for entrance.

Exactly how these various persons will work together to provide better health service to children is not known. However, it is known that today physicians must by necessity devote more of their time to children with acute health problems. It has been shown that pediatricians are now spending 50 per cent of their office time with patients giving well child care and another 22 per cent in treating upper respiratory infections of children.¹ When working in association with a physician, nurses can provide much, if not all, of what is usually called well child care and perhaps certain types of care for the sick or injured child. If well child care is to be provided by personnel other than physicians, those in nursing must decide if nurses are to accept the responsibility and fill this role in providing health care.

Physician's assistant is a title given to various people who are assuming a role in health care. Their role in relation to the total health care system is not well defined in many instances. Some nurses are becoming physician's assistants, but this role for the nurse has been rejected by some as depleting the ranks of nursing. However, Dr. Dorothy Mereness, dean of the School of Nursing of the University of Pennsylvania, in a speech in March, 1970, stated that "the use of the well-prepared nurse in the extended role of the physician's assistant might reestablish the time-honored and still needed practices of visiting patients in their homes, responding

to night calls, delivering mothers at home, improving the care of well children and focusing attention on the family as a unit of care." She also said that some "... nurses believe that the well-prepared public health nurse traditionally provides many of the services which are now being suggested for the physician's assistant." She continues "... many physicians still are unaware of the knowledge and skill today's nurses are able to bring to their patients."² Nurses must demonstrate nursing to physicians.

Comprehensive Nursing Care

Today there is the opportunity for the individual public health nurse to not only extend her skills but to use all of her skills to give better health care to patients ... adults and children. In Georgia, some public health nurses have extended their roles and are giving comprehensive health care to children.

In August, 1968, in DeKalb County's nine health centers, public health nurses began to extend their services to the children of that community through nursing child health conferences as well as medical child health conferences. In the nursing child health conference the nurse appraises the child to determine if he is developing normally or abnormally. If the nurse is suspicious that a child is developing abnormally, she refers him to a physician. In this way the physician's time is utilized more efficiently. Whether his development is felt to be normal or abnormal, each child is referred to the physician for a thorough medical examination at least once during infancy and the pre-school period.

From January 1969 through June 1969 a study of the newly developed nursing child health conference program in DeKalb County was done by the Child Health Service of the Georgia Department of Public Health. The data from this study shows 1) that the nurses were referring 84 per cent of the children properly, with a 10 per cent under-referral

* Consultant Nurse, Child Health Service, Ga. Department of Public Health. Lillian P. Warnick, M.D., Director.



FIGURE 1

The public health nurse talks with the mother about her infant's growth and development. Here she stresses the importance of good nutrition. Guidance from the Nutritionist on the Child Health Service staff is a part of the in-service on Nursing Appraisal of Children.

rate and a 6 per cent over-referral rate; 2) that most of the parents, physicians and nurses accepted the nurse in her new role and 3) that most of the nurses felt the need for further skill in and tools for developmental appraisal.

Instruction

In order that public health nurses in other counties throughout Georgia could extend their roles in nursing appraisal of children the Child Health Service staff prepared instructional guides and since August, 1969, has instituted in-service sessions and follow-up consultation in 10 health districts of the state. The nurses in these districts are in various stages of assuming extended roles in providing child health supervision. In-service sessions are planned for nurses in other health districts in the coming months, and more extensive workshops are now being held in order to give additional opportunities for nurses to increase their knowledge of and skill in nursing appraisal of children and counseling parents regarding nutrition and growth and development.

In Lowndes County the district health director who is a pediatrician is acting as consultant to the nursing staff to assist the nurses in extending their

roles in child health care. In Union County the local public health nurse does appraisal of children as she determines the need. This may be when the child comes in with another member of his family who is receiving a service. She refers those who she feels need to see a physician to a private physician's office. In Cobb County's health centers, the nurses are holding nursing child health conferences as in DeKalb but are referring children to a private pediatrician's office rather than a medical child health conference.

In Fulton County, the pediatrician who is in charge of child health care in that county is conducting a more extensive in-service program for eight nurses at the time. She is including in her courses the use of the stethoscope and otoscope and is providing clinical experiences in Grady Memorial Hospital's out-patient department.

Appraisals

Appraisals can be done in nursing child health conferences or on an individual basis whenever the nurse sees a child in a health center or in a home. Referral arrangements can be made to a medical conference, the medical district health officer or a private physician in his office.

A thorough nursing appraisal of the child is done by gathering data through an interview with the parent and observation of the child and parent (Figure 1). The appraisal process includes the use of the Denver Developmental Screening Test (Figure 2) and a physical appraisal (Figure 3) and should determine nutritional, growth, developmental and physical deficits and strengths.

The appraisal process aides the nurse in:

1. Early discovery of the child who needs med-



FIGURE 2

The public health nurse observes gross motor, fine motor-adaptive, language and personal-social development by using the Denver Developmental Screening Test. Here the nurse checks fine motor-adaptive skills.



FIGURE 3

The public health nurse closely observes the infant from head to toe while doing a physical appraisal.

ical or other health attention and who needs referral to his private physician if available, health department physician or other appropriate resource. The majority of children seen will probably not need referral but can be followed by the nurse instituting appropriate nursing actions.

2. Guidance of each parent regarding normal growth and development with:

- a. Support of those whose children are developing normally and
- b. Supportive counsel to those who want or need to implement changes in the care of their children.

3. Evaluation of the progress of children to whom she is providing follow-up care.

4. Initiation and continuance of health teaching.

Maximum Skill Utilization

The extended role of the public health nurse in child health supervision in Georgia encompasses the maximum use of all of the nurse's skills to provide better health care for children. The nurse using her basic skills of observation, knowledge of growth and development and family centered supportive skills can do a thorough nursing appraisal of the child and can determine what health needs are present. She can then formulate a nursing care plan and implement appropriate nursing actions, evaluating her actions and making changes as needed. As the nurse assumes an extended role she is using the nursing process to give better care to children.

There are questions answered and unanswered that emerge from consideration of this topic. Some of these questions are:

What can each nurse do in extending her own role using the skills and knowledge she now has?

What additional preparation does the nurse need to assume an extended role?

What role should the nurse assume and what roles should other allied health personnel assume?

How will all allied health workers cooperate to provide better health service?

Is preventive child health care a service public health nurses should provide?

What should be included in preventive child health care?

What are nurses doing now that is less important as a nursing function than child health care?

Who can assume these less important functions so that nurses can give nursing care to families including children?

Child Health Service is attempting to answer some of these questions. Public health nurses are uncovering some of the answers as they function in extended roles in giving child health care. Some feel more comfortable in the role than others. Some feel more secure in counseling parents than others; some feel more secure in appraising a child than others. But some are giving comprehensive health supervision because they are individually extending their own roles with support and guidance.

Every nurse can extend her role—in one way or another. She may need support in some areas; she may need further preparation in some areas. But nurses need to use nursing skills to give nursing care to the people of our communities and allow other personnel to take on non-nursing functions. Nurses working in cooperation with physicians and other allied health workers throughout the state can help to provide child health supervision to the children of Georgia.

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NUTRITIONISTS TO HOLD MEETING

The Twelfth Annual Meeting of the American College of Nutrition will be held in New Orleans, Louisiana, on Sunday, November 28, 1971, in the Grand Ballroom of the Royal Sonesta Hotel. The one-day program includes a symposium on hyperlipidemias and atherosclerosis and a discussion of nutrition in outer space. Hotel reservations should be made through the AMA Housing Bureau.

*Step by step management of this
life-threatening condition is outlined
and discussed.*

Gram-Negative Sepsis, Management in Urology

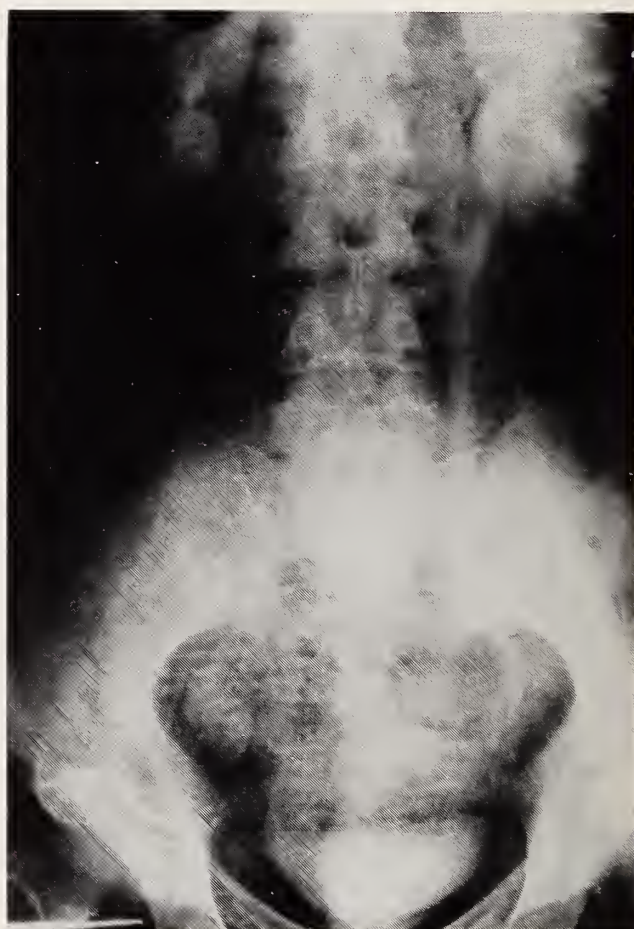
WILLIAM S. HITCH, M.D., and PETER L. SCARDINO, M.D., Savannah

GRAM-NEGATIVE BACTEREMIA has become the leading cause of death in septicemia. Reported mortality rates continue to range from 20 to 70 per cent in spite of the use of potent antibiotics.¹ Recent studies² have, however, provided a rationale for the treatment of gram-negative sepsis. Most cases can be successfully managed with the resources available in any community hospital. The following case report is an example of our approach to the management of this problem.

Mrs. V. H., a 59-year-old housewife, was well until three hours prior to admission, when she experienced an abrupt onset of severe left flank pain, nausea, vomiting, and shaking chills. She had no past history of urolithiasis, urinary tract infection, or previous serious illness or surgery. On admission to the emergency room, she appeared acutely ill and very toxic. Her temperature was 105.4°, pulse 140, and her blood pressure 60/40. She had extreme left CVA tenderness, but no additional pertinent physical findings.

A rapid infusion of 5 per cent Dextrose in Ringers Lactate was begun, using a 16 gauge polyethylene catheter inserted in an antecubital vein. Blood for laboratory studies and culture were obtained during this procedure. A Foley catheter was placed in the bladder. A polyethylene catheter was placed through the external jugular vein into the superior vena cava in order to monitor central venous pressure. Eighty mg. of gentamicin was given intramuscularly, and 10 million units of penicillin was added to the IV fluid.

Still hypotensive, she was transferred to the radiology department. An infusion IVP (figure 1) demonstrated a distal left ureteral calculus with pyelosis and parenchymal extravasation. The diagnosis was made of acute left ureteral obstruction with super-imposed gram negative septicemia and shock. Laboratory studies that were available included: Hemoglobin 14.0 grams per cent; hematocrit 43



per cent; white count 11,800 with 76 segs, 22 lymphs, and 1 band; sodium 143; potassium 3.8; chloride 110; carbon dioxide combining power 22 and BUN 15. The "protime" was 100 per cent, the Fibrindex 10 seconds, and the platelet count 83,000. The Lee White clotting time was 9 minutes. Urinalysis revealed only 0-3 WBC and rare RBC.

Fluid therapy was continued with lactated Ringers solution in quantities sufficient to keep the central venous pressure above 10 cm H₂O. Two hundred fifty mg. of methylprednisolone was administered initially, followed by 40 mg. every four hours, 7500 units of heparin every four hours, 80 mgs. of

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gentamicin every 6 hours and 30 million units of penicillin every 24 hours.

The vital signs, output, and central venous pressure were determined at 30-60 minute intervals. Eighteen hours after admission, the patient had become normotensive and afebrile. Her urine output had risen to 40 cc. per hour. Repeat coagulation studies showed a protime of 70 per cent, partial thromboplastin time of 102 seconds with a control of 66 seconds and a platelet count of 31,000. Lee White clotting times were maintained at 3 times control levels. Thirty-six hours after admission, the steroid and heparin therapy was discontinued, and a stone extraction was performed.

The patient thereafter recovered very rapidly. The laboratory studies returned to normal, except for the platelet count, which remained at low, though rising levels. The patient was discharged on the seventh hospital day.

Discussion

Management of a case of gram-negative sepsis may be outlined as follows:

Initial Care: Intravenous fluid therapy, using the largest catheter (or needle) practicable, and insertion of a Foley catheter in the bladder are the initial steps. Careful intake and output records are kept. A catheter should be placed in the superior vena cava for central venous pressure monitoring. In this case, the external jugular vein was used. This vessel may be exposed by a small incision or by percutaneous puncture. The internal jugular vein may similarly be used.³ In less critical situations, a 42-inch #8 French infant feeding tube threaded a cutdown in the median basilic vein is preferable. The feeding tube is much more pliable and less reactive than the commercially available catheters. No surgical complications or cases of thrombophlebitis have been encountered using this technique. Percutaneous subclavian vein puncture has been advocated,⁴ but this route should be reserved for those clinicians who have experience with the procedure. Regardless of the method used, the determination of central venous pressure is essential in the management of gram-negative sepsis. The interpretation of central venous pressure has recently been reviewed.⁵

Pressor agents were not used in this patient. These drugs have no place in the initial management of bacteremic shock.

Laboratory Studies: The blood for laboratory determinations and culture is obtained as the initial step in IV fluid therapy. Similarly, urine for analysis and culture is obtained at the initial catheterization. Both a chest X-ray and an infusion pyelogram are obtained as quickly as possible. The urinary tract is

often overlooked as the site of infection. The patient's symptoms may direct the physician's attention elsewhere, or a negative urinalysis, as in this case, may be misleading. This case well illustrates the hazards of omitting the IVP in the evaluation of the septic patient.

Drug Therapy: Since parenteral gentamicin is now available, our preferred therapy for septicemia is gentamicin in combination with high doses of penicillin. In the patient allergic to penicillin, we use gentamicin alone or in combination with cephalothin.

Controversial Procedures

The use of glucocorticoids is under investigation. Retrospective studies appear to show a significant improvement in mortality rates.⁶ The rationale underlying the use of steroids is based on their role in lowering peripheral resistance⁷ and in stabilizing cell membranes.⁸ The drugs must be used in pharmacologic doses. A recent recommendation from Lillihei² is that hydrocortisone should be given in a dose of 50 mg/kg/24 hours. When used over a short period of time—several days or less—the drug need not be tapered, and may be stopped abruptly.

Heparinization is also a controversial procedure. The literature on the subject is voluminous, and no attempt has been made to summarize the arguments. However, Corrigan, et al.⁹ recently presented evidence that abnormal coagulation studies—and presumably disseminated intravascular coagulation—occur in nearly all patients with gram-negative septicemia and shock. We rely primarily on a depressed platelet count in making the diagnosis. No complications have been observed attributable to heparin.

Operative Intervention

The source of this patient's infection was a ureteral calculus. A successful stone extraction was performed on the third hospital day, obviating the need for more extensive surgery. However, all of the therapeutic tools discussed above may only serve to buy time for the surgeon. In amenable cases, surgical intervention should be performed as soon as the patient is stable. The availability of new and more potent antibiotics, the development of more sophisticated monitoring techniques, and the use of more exotic therapies such as steroids and anticoagulation have converted surgery in these critical cases to an elective procedure. The clinician, however, should not be tempted to rest on his laurels. Identification of the etiology of infection should be made as rapidly as possible, and definitive therapy promptly instituted.

Memorial Medical Center

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TOO FEW DOCTORS?

Mr. Harry Schwartz*

Many popular clichés in the current national debate about reforming the nation's medical system were badly battered this past week at the intensive discussions of the Sun Valley Forum on National Health.

The most striking conclusion of the forum was that "a very large number of Americans are over-doctored, over-hospitalized and over-drugged." The forum thus challenged the common notion that the way to improve the nation's health is to go on increasing the volume of medical services and simply pouring more money into the medical system. Rather, the need is for better allocation and more intelligent use of existing medical resources—together with better sense in the way Americans take care of themselves.

Millions of Americans would benefit more from changing their dietary habits, losing weight, exercising, stopping cigarette smoking and cutting down or ending their consumption of alcohol and other drugs than from having more physicians and more hospitals available to treat them after their bad habits laid them low.

Maldistribution

Prof. Victor R. Fuchs of the National Bureau of Economic Research questioned whether the United States is suffering from a great shortage of physicians. His studies indicate excess capacity among American physicians, particularly among general surgeons, some of whom operate so infrequently that one listener wondered how they can retain their skill to do complex surgery. Maldistribution of physicians, both geographically and in terms of specialties, may be at the root of complaints about a doctor shortage.

The poor in America doubtless need better medical care; poverty itself causes much physical and emotional illness. However, Professor Fuchs said, "the poor in this country probably have more access relatively to medical care than they have to most other goods and services. It is the terms and the conditions under which they receive such care that cause much of the discontent."

The effort to solve health problems with more resources rather than through better allocation and use of resources underlies the galloping inflation which has boosted the nation's health bill to about \$75 billion

annually, 7 per cent of the gross national product, with no end to the escalation in sight. Hospital cost reimbursement formulas used by Medicaid and Medicare were singled out for special criticism since they provide hospital managers with little or no incentive for efficiency or holding down costs.

Limited Resources

Profs. Herman M. Somers and Anne R. Somers of Princeton University estimated that the United States health care bill will exceed \$100 billion before 1975. They quoted a British critic who said, "Expenditure for medical care is a bottomless pit," while the nation's resources are limited.

The limits were stressed in another way by Dr. Charles L. Schultze of the Brookings Institution, who argued against trying to put the whole cost of the nation's medical care on the shoulders of the taxpayers. The nation has many other very high priority tasks—for example, rebuilding the slums of the inner city—which can only be accomplished through the tax system. So far as possible, therefore, Dr. Schultze maintained, the costs of medical care should be paid through the private sector, not loaded onto the already overburdened Federal budget. About 70 per cent of the nation's citizens, he argued, can afford to meet their medical costs—except for catastrophic illness—from their earnings without outside help.

At a time when Congressmen are starting to try to outbid each other on massive new programs for national health care, the Sun Valley Forum has raised some cautionary flags about the kind of programs that are really needed and can do the most good. The nation doesn't yet know why the existing huge outlays on medical care do not produce better results. And it could use more evidence—from sizable experiments in new medical delivery systems—before rushing into a radical restructuring of the entire medical system. With so many tough questions, so few sure answers, and limited resources, the immediate need is for programs that zero in on high-priority goals, such as directly providing physicians and medical services under decent conditions for the poor in urban slums and for many in remote rural areas, and tightening cost controls and increasing incentives for efficiency for those who manage the nation's hospitals.

* Member of the editorial board, *New York Times*.

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Cervical Cancer Screening Program

JACK M. LANDRUM* and ALBERT K. SCHOENBUCHER, M.D., FACOG,† Atlanta

THE GEORGIA CERVICAL CANCER Screening Program for the early detection of carcinoma of the cervix utilizing routine Pap smears was established by the Georgia Department of Public Health with the approval of the State Board of Health in February 1967. Eligibility for this screening service is determined in conformity with policy set by local boards of health. It is recommended that local policy make cervical cancer screening service available to indigent and medically indigent women of all age groups who do or would normally seek care in local health department clinics in the state. All citizens and guests of the state are eligible for the educational programs. This public health program is supported by 29 pathology laboratories in the state, district health directors and staffs of local health departments, and private physicians who serve as clinicians and those who ultimately accept for care patients requiring further study, evaluation, and treatment as the result of a suspicious or positive Pap smear. (Ref. *J.M.A.G.*, July 1967, Vol. 56 and *J.M.A.G.*, Oct. 1968, Vol. 57.)

The primary purpose of the Cervical Cancer Screening Program is the detection of unsuspected cervical malignancy in the earliest stages when the cure rate is 100 per cent. The secondary purpose is to educate medical, nursing, and sub-professional persons and the population at large about carcinoma of the cervix, and the value of the Pap smear in early detection. The goal of this service is to increase casefinding in cervical carcinoma at the earliest, curable stage of the disease and thus decrease morbidity and mortality in women due to carcinoma of the cervix.

Leading Cause

Cervical cancer is one of the leading causes of death from cancer among women. The death rate

from all uterine cancer has declined significantly since the late 1930's (75/100,000 women aged 20 and over in 1936 to 20/100,000 in 1970) partially through the wider use of the Papanicolaou smear as a diagnostic tool for early diagnosis and treatment. Still, cervical cancer is the cause of death for around 200 women in Georgia each year. (See Table I.)

TABLE I
DEATHS FROM UTERINE CANCER, GEORGIA

Type	1967	1968	1969	1970
Cancer of Cervix	200	227	203	179
Cancer of Uterine Body	25	26	31	18
Cancer Uterus, Unspecified ...	71	74	75	93

Because of program growth, it was necessary in 1970 to computerize data which provide better follow-up procedures, planning, evaluation, and serves as a base for the eventual establishment of a tumor registry.

From the beginning of the program in 1967 through December 31, 1970, 83,776 Pap smears were performed in local health department clinics throughout the state and reported as:

Class I	73,387	} 98.1 per cent negative
Class II	8,810	
Class III	874	} 1.2 per cent suspicious and positive
Class IV	113	
Class V	17	
Unsat/Insuff	575	0.7 per cent

The fact that more than one-half of those reported as unsatisfactory/insufficient quantity were broken in transit is an indication of the commendable efforts of clinic personnel.

The total number of patients with suspicious or positive Pap smears during this period is 915; however, repeat smears account for the total number of Classes III, IV, and V being 1,004. Of the 915

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CANCER / Landrum and Schoenbucher

patients, 560 were diagnosed as nonmalignant. These were patients with dysplasia, chronic cervicitis, or other conditions which, through the Pap smear, was called to the attention of the patient and treatment given to relieve discomfort and possible danger of more serious consequences. Seventy-six patients remain in various stages of follow-up such as awaiting

appointments or repeat smears after a time period. Forty-three patients are lost to follow-up through relocation leaving no forwarding address or through fear or other reasons refuse further study and evaluation.

A total of 236 cases of cervical cancer have been diagnosed through December 31, 1970 (see map). Of the 198 cases diagnosed as intra-epithelial carcinoma of the cervix, 179 were treated by major surgery, 16 by minor surgery, and 3 have refused recommended treatment.

Follow-up information on 38 cases of invasive cervical cancer received from clinics and private physicians shows the following: 26 were treated by radiation therapy, 10 by major surgery and 2 have refused recommended treatment.

MATERNAL HEALTH SERVICE
CERVICAL CANCER SCREENING PROGRAM CASES DIAGNOSED AND TREATED
FEBRUARY 1967 - DECEMBER 1970



Stages

Stages were assigned as follows:

I	18 (44.7%)
IA	3 (7.9%)
IB	6 (15.8%)
II	5 (13.1%)
IIB	2 (5.3%)
III	2 (5.3%)
IIIA	1 (2.6%)
IV	1 (2.6%)
Total	38

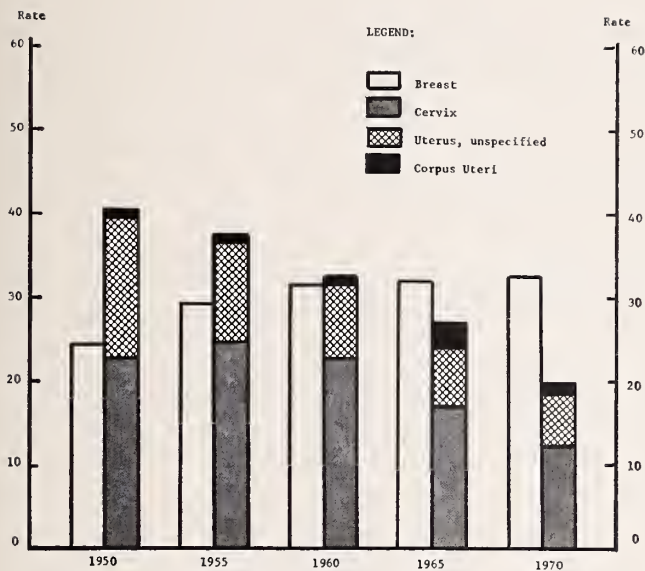
The median age at diagnosis for the intra-epithelial cases is 30.7 years and for invasive, 36.6 years. The median parity for 196 cases of intra-epithelial cervical cancer is 4.9 (2 unknown); for

TABLE II
AGE AND PARITY OF 236 PATIENTS WITH CERVICAL CANCER

Parity	Preinvasive Carcinoma		Number
	Number	Age Group	
0	2	less than 20	1
1	15	20-24	28
2	19	25-29	74
3	31	30-34	44
4	39	35-39	28
5	20	40-44	13
6 and over	20	45-49	6
Total	198	50 and over	4
		Total	198

Parity	Invasive Carcinoma		Number
	Number	Age Group	
0	0	less than 20	1
1	6	20-24	3
2	5	25-29	8
3	1	30-34	8
4	3	35-39	8
5	3	40-44	3
6 and over	20	45-49	0
Total	38	50 and over	7
		Total	38

TOTAL RATES OF DEATHS OF FEMALES,
FROM CANCER OF SPECIFIED SITES,
GEORGIA, 1950-1970

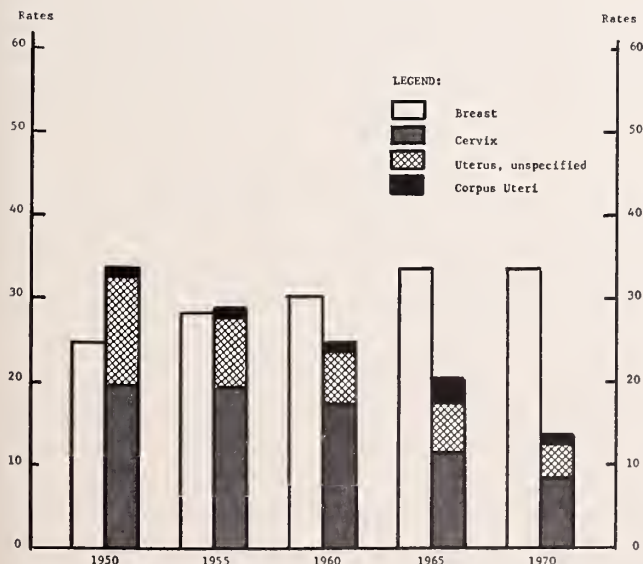


Rates are per 100,000 Females 20 years and over.

invasive 5.2 (see Table II). The age range for the intra-epithelial cases was 19-60 and for invasive carcinoma, 17-69. One hundred and forty-seven were referred to state-aid or other agency clinics, 88 were accepted by private physicians, and one was referred to an Army hospital for treatment.

The significant accomplishment of the program

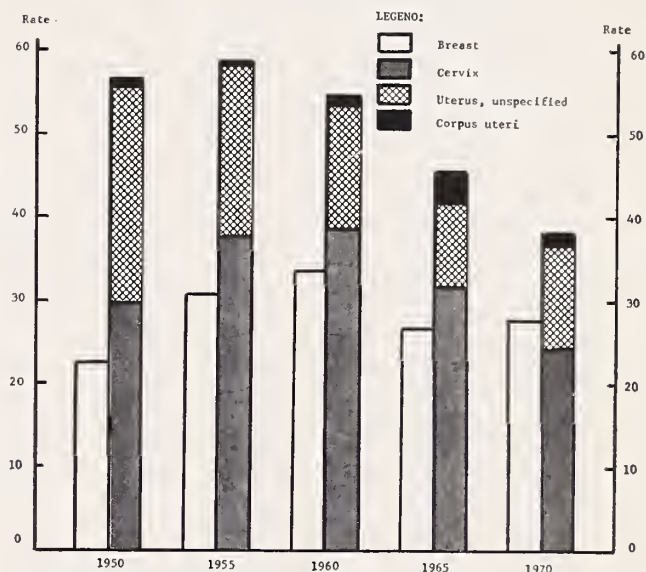
RATES OF DEATH OF WHITE FEMALES,
FROM CANCER OF SPECIFIED SITES,
GEORGIA, 1950-1970



Rates are per 100,000 Females 20 years and over.

lies in the number of cases of intra-epithelial carcinomas detected and brought to treatment. Prior to the institution of service, referrals to tumor clinics had been made on the basis of clinical symptoms and physical findings alone and in the majority of cases malignancy had advanced to stages where the five-year survival was less than 50 per cent.

RATES OF DEATH OF NONWHITE FEMALES,
FROM CANCER OF SPECIFIED SITES,
GEORGIA, 1950-1970



Rates are per 100,000 Females 20 years and over.

There has been a significant change in the rates of death from breast and uterine malignancies in Georgia during the past 20 years. While deaths from uterine cancer have been reduced by half (40 to 20 per 100,000 women aged 20 and over) the deaths from breast cancer have increased by about a third (24 to 33 per 100,000). Rates by race show that the decline in uterine cancer deaths is occurring in both races although the incidence remains over twice as great among non-white women. Death from breast cancer is increasing among white women but has shown very little variation among the non-white (Charts).

During the past two years, public health nurses have been instructed to perform Pap smears as a part of the general health appraisal of their women patients, and currently they are being instructed in breast examination and to teach their patients breast self-examination as part of extending and broadening health services.

47 Trinity Avenue, S.W.

The Early Days of MAG

J. G. MCDANIEL, M.D.,* *Atlanta*

MY EARLIEST EXPERIENCES with the Medical Association of Georgia were in 1929, when I attended the Annual Session in Macon. I participated in some of the meetings and listened to some of the surgical papers. They were good. It came as a distinct surprise to me to learn that some of the physicians in small towns knew as much or more about surgery than I did, and I have never forgotten it.

In the 1930's, MAG was run primarily by the Secretary-Treasurer. He, as far back as I know, was always an Atlanta man, since the Headquarters Office was in Atlanta. All correspondence cleared through him. All monies were collected and paid out by him. He knew who would work on committees and who would not. He was Editor of the *Journal*. He kept up with the goings-on in the AMA, the State Legislature and so forth. After all, the President had only one year of office.

The first Secretary-Treasurer that I knew was Dr. Allen Bunce. He was in office from 1921 until he retired of his own accord in 1935. Dr. Bunce was a dynamic man, a hard worker as a private practitioner and for the MAG. He could call by name most of the doctors in Georgia. I asked him once how he had developed this admirable trait. He told me that during his tenure of office that, if he were going to visit a County or District Society, he would get the Roster and go over and over the full names of all the members. In that way, if he were introduced to a doctor, he could immediately call him by his full name. Many times he rode the train and this was a delightful way to pass the time.

In 1935 Dr. Bunce wrote the functions of the State *Journal* as he saw them. When all is said and done, he said, it is not possible to publish the advances of pure science nor to elaborate procedures possible in only the most expensively equipped hospitals, nor to publish discussions of the rare conditions encountered in great medical centers, nor to be the organ of any group of specialists. The function of the State *Journals* is to keep the general practi-

tioner abreast of the progress in clinical medicine and to allow him to give other practitioners the benefit of his actual experience—to keep the doctors aware of legislation, favorably or unfavorably—and to promote solidarity and friendship among the members by informing them of the doings of each other.

Elections

When Dr. Bunce retired, a young associate of his, Dr. Mark Dougherty, was nominated to take his place. Now some of the brothers felt that the office of Secretary and Treasurer should not remain in one office indefinitely, and the name of Dr. Edgar Shanks was placed in nomination.

I did not know either of them but my uncle, Dr. Zack Cowan, with whom I was associated, was in the War in France with Dr. Shanks and was quite fond of him. Thus, I was a Shanks man. In those days, the nominations and voting took place on the last day of the Annual Session. Only those present voted. When the vote was counted that day between Dr. Dougherty and Dr. Shanks, it was a tie and they had to vote over again. About that time Dr. Charlie Wasden and John I. Hall from Macon, with whom I was in school, came to me and asked me who I voted for. They said that they knew neither of the candidates and voted for Mark Dougherty only because Dr. Charlie Richardson from Macon had asked them. I told them how I voted and why. On the next ballot, Dr. Shanks won by four votes.

Years later, Dr. Mark Dougherty became one of my best friends, and I told him about what had happened. He thanked me profusely for what I had done and said that he really didn't want the job, but that Dr. Bunce had talked him into running.

Conservative Officer

I have often wondered how this affected the future of the Medical Association of Georgia. Dr. Shanks took over and more or less ruled MAG with an iron, but dedicated, hand. His burning desire was to build a building to house the Association, and throughout his tenure of office he searched for ways and means

* Presented at the 13th Annual MAG County Society Leadership and New Member Indoctrination Conference, February 6-7, 1971, Sheraton Biltmore Hotel, Atlanta.

to bring in money and keep it for that purpose. If some of the Presidents and Committees wanted to do some things that cost more than Dr. Shanks thought they should, they just never did get done. This is not to say he was not for progress. He went along with reasonable things, but he always wanted to end the year with a few thousand dollars added to the savings account for the Building Fund.

In the 30's, the Council met the day before Annual Session and the day or afternoon after Annual Session to outline business for the coming year, and on call by the President. No other meetings were held. It is perhaps for this reason that the Secretary and Treasurer made all the decisions between the meetings of the Annual Session.

Let me speak further on the elections of officers that were held on the last day of the Session. An interesting election was held in Columbus, in 1922. Usually the election of the President was a cut-and-dried affair controlled by the hierarchy—often, not more than 25 doctors remained for the meeting on the last day. I do not know this for a fact, but the story goes that Atlanta was going to put up Dr. E. C. Thrash for President, a very fine doctor and gentleman. Everything had been worked out with no problems, but on the night before the last day of the meeting, it was learned that Columbus was going to put up a man for President who was also a very fine doctor and gentleman. Columbus, with 30 or 40 doctors present on the last day, could elect anybody. Many frantic telephone calls went out to Atlanta, Savannah, Macon, Augusta and many small towns. Model T's bit the dust that morning, coming back to Columbus to vote. Dr. Thrash was elected by two or three votes.

The doctors in Columbus were most upset by this. They felt that the entire state was against them, and it has only been within the last 15 or 20 years that this impression has been corrected and they have been enthusiastic about the Medical Association of Georgia. Since that time it has been an unwritten rule that—the President should not run for office in his own hometown.

Journal Idiosyncrasies

One thing that I have noted in reviewing the *Journals* from 1930 to 1940 is the attention paid to the individual doctors and what they did, not what the MAG did as an organized body. The reports of meetings of MAG were complete with members listed as attending, many times with pictures of the officers. Committees were listed by names, but not their reports. Minutes of the House of Delegates were hard to find and the Council minutes almost never appeared. Papers presented at meetings took over the *Journal*. Some were good, some were not. They

covered topics from pneumonia, childbirth, scarlet fever, appendicitis, malaria, typhoid and typhus fever, the common diseases.

In the late 20's and early 30's, there was a lag in publishing of the *Journal* in an up-to-date manner. Dr. Marion Pruett was appointed Business Manager. Some papers at that time were poorly presented and had to be edited and proofread. Dr. Pruett worked hard and finally got the *Journal* on its feet but stated plainly to one and all that he could not do this and practice medicine. Therefore, Mr. H. L. Rowe was employed as a full-time Executive Secretary and Editor of the *Journal*. I do not know what his salary was in the beginning, but it was listed in 1931 as \$150.00 a month. Dr. Minor Blackford wrote several articles in the *Journal* beginning in 1930 on how to write a paper for publication. The one thing he stressed was that, if a poor paper was read at the State Convention, no amount of editing could make it a good paper.

In the 1939 *Journal*, an interesting report appeared from the Chairman of the Board of Health, the Honorable Robert F. Mattox, a layman, who had been on the Board since 1913. He discussed its problems, monies and so forth. In addition to these truths, he added, "Unfortunately, we have seen an effort made to have the Federal Government encroach upon the management of the medical profession, as it has on so many lines of business. I believe the keynote of the new deal can now be said to be, 'let the Federal Government do it.' This siren song has found its echo in the hearts and minds of millions of men and women. It has palsied ambition, dulled the pioneering spirit of our individual efforts, which have made our country great, and if not silenced will lure it to destruction. Seeds of indolence have been sewn throughout the land and I feel the crop will reseed itself for many years. High federal taxes and low politics united in unhappy wedlock breed waste and extravagance which can only be fed by the false political appeal of helping humanity."

Finances

Finances in the 30's were quite interesting. Dr. Bunce reported in 1933 that the Treasury listed an income from all sources of \$11,565.40. Among those listed was a \$3.75 dividend from a closed bank. I never could find the bank that had closed or how much money we lost in it. Dr. Bunce carried about a \$5,000 cushion at all times. Attention should be called to the fact that our lawyer, Mr. Grover Middlebrooks, in 1933 went to Jacksonville, Florida, to get a deposition to represent a doctor in Valdosta, Georgia, who had been sued. His expense for the deposition and the trip was \$38.60. Councilors in those days were paid their expenses to District meet-

ings and to State meetings. Their usual expense turned in was about \$20 per year. A tip-off in the late 30's about money, for example, is in the listing of 1938 hotel rates in Augusta, Georgia for the Annual Session:

Forrest Hills, double room, two people with three meals a day—\$7.50 each

Partridge Inn, double room, two people, three meals—\$6.50 each

Richmond Hotel, double room, two people, no meals—\$3.50 a day

Margaret Hamilton Hotel, double room, two people, no meals—\$1.75 a day

In 1937 the House of Delegates set the dues at \$7.00 per year. There was much squawking, and it passed by a slim majority. Then came the War and I was away from May of 1941 until 1946. When I got back I found that MAG had \$56,000 in the kitty as a cushion and was spending about \$37,000 per year.

New Regime

In 1951 there was a decided change made in the affairs of the Medical Association of Georgia. Dr. Shanks was not in good health. He had assets in the Treasury of some \$112,230.57, but many of the brothers had gotten upset because of his frugality. They felt that he was not progressive but, as has been stated before, Dr. Shanks' burning desire was to build a home for the Medical Association of Georgia.

Dr. Henry Poer defeated him in 1951. He had altogether different ideas from Dr. Shanks. Dr. Poer wanted to make the Medical Association of Georgia the finest State Medical Association in the United States. In order to achieve this ambition he wanted a very fine *Journal* and needed extra help in the office and a good Public Relations man. His first step was to employ Mr. Sid Riseman as Public Relations man and Executive Secretary. He later added two more people as part-time employees—a Mr. Gasaway and a Mr. Fort. He surveyed all the property of the Medical Association of Georgia. If unnecessary or out-of-date, it was discarded and dictaphones, modern filing equipment and so forth, were installed. All this time we were in the basement of the Academy of Medicine.

In 1952 at the Annual Session of Atlanta, he managed in one way or another to have 11 out-of-town speakers on the program, which was unheard of. Usually we had only a few.

It was in 1952 that he employed Miss Thelma Franklin as bookkeeper. She is, thankfully, still with us, bless every bone in her body.

In 1953 Mr. Riseman resigned and Dr. Poer recommended to Council the name of Mr. Milton Krueger to be Editor of the *Journal*, Public Relations man and Executive Secretary. Mr. Krueger and Dr. Poer complemented each other. Everything was run-down and in foul shape according to their standards, and needed tremendous improvement. So much so that later on in 1953, Dr. Poer recommended that Dr. Edgar Woody be made Editor of the *Journal* so that Milton could devote his entire time as Executive Secretary and Public Relations man. This was done and great was the wisdom of the Council and House of Delegates in affirming these recommendations. Of course, all of this cost money and there was an increase of dues from \$15.00 to \$25.00 over mild opposition. In 1954, however, when there was a \$10,000 deficit spending in spite of the dues increase, there was considerable discussion, not mild to say the least. I don't think that worried Dr. Poer much, because he had made a great deal of progress, but it upset the President, Councilors, the Finance Chairman and Mr. Krueger.

Association Changes

The *Journal* had made great improvements. There were many papers from prominent out-of-town speakers at the Annual Session. The format had changed. Edgar Woody was doing a good job. During these years Council meetings were changed from the day before and the day after Annual Session to at least every four months during the year, and the Executive Committee was to meet monthly. The By-laws were rearranged so that the Secretary and Treasurer could not be elected for more than two consecutive terms and that the Secretary and Treasurer be separated. The Secretary was to be elected and the Treasurer was to be appointed by Council, without the right to vote in Council. Dr. Raymond Arp was our first Treasurer to be so appointed.

In 1956 the brothers were again upset by \$5,000 deficit spending, but there had been a flash flood in the Academy of Medicine building which cost about \$2,000 in damages.

In 1955 Mr. John Kiser was employed as a field man to take over the chore of legislation.

In 1956 and 1957 a storm was brewing at Talmadge Memorial Hospital and Emory University Clinic about taking private patients.

All these years the Woman's Auxiliary went plodding along doing their very excellent work and writing up good and concise reports in the *Journal*. I could understand their reports but not ours. Their husbands did not pay too much attention to them. After all, they were just their wives—God bless them, nevertheless.

In 1957, doctors were complaining of too many

out-of-town speakers, too many specialists. Doctors from small and medium towns could not get on the program.

New Offices

In 1957 Dr. Chris McLaughlin was elected Secretary. Dr. Poer had had two terms and could not run again. It was during this year and in 1958 that the basement of the Academy of Medicine closed in on us. We had to have more room if we were to keep progressing. A Committee was appointed to study the situation and bring reports to Council and the House of Delegates. The Committee worked rather diligently, getting prices on vacant homes on Peachtree, vacant lots around town and so forth with idea of building on them, but most time was spent on a thought advanced by several, that we get a long-term lease on a portion of land on the back of the lot owned by the Academy of Medicine and to build an office there, with the bottom floor a parking deck and two floors above it for our needs. Some enthusiasts on both sides even had some temporary plans drawn. This had some merit to have both organizations on the same lot, but further reflection

by members of both groups tabled it. For example, if we had a long-term lease and Fulton County wanted to sell their property, they couldn't without our consent: or, if we wanted to expand our building there might be complications.

In 1959 the Gulf Life Building at 938 Peachtree had become vacant and was up for sale for \$190,000. The Committee looked at it carefully and recommended to Council and the House of Delegates that it be purchased. The Medical Association of Georgia in their wisdom bought it and the staff promptly moved in. They were the happiest people you ever saw. Plenty of space, no musty basement rooms, no threat of floods, good heat and good air-conditioning. They had mostly new furniture, desks and draperies. They felt as though they were really "somebody" with an address of their own on Peachtree Street.

And so, I cut off in 1959 with the move into the Gulf Life Building. I am quite familiar with the wonderful things that have transpired since, but don't ask me about them. It would be like asking a proud father about his children who have done well—I just might take you seriously.

508 Loews Grand Theater Building 30303

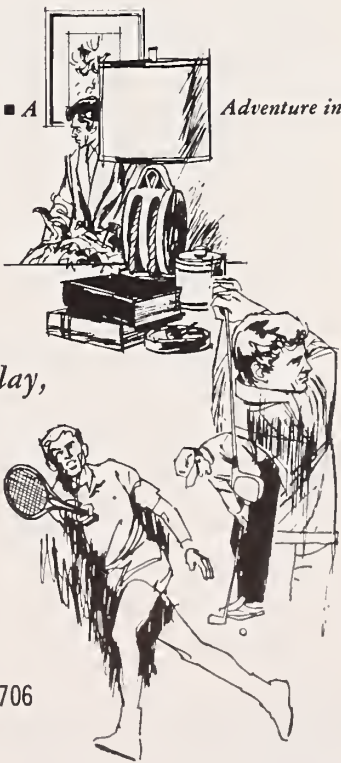
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THE POLITICAL PSEUDO-HYPOCHONDRIACS

THE PREFIX "PSEUDO" is used here because I do not believe our politicians (those that rant, rave, and fume for a change in our medical system) are stupid enough to actually believe what they keep preaching. Neither do I believe that they swallow the piles of political propaganda with which they create a Sargasso Sea of sticky confusion. When they say over and over that our system of medical care is sick, sick, sick, they know all the time that this just isn't so, and that America has access to the finest medical care in the world, far surpassing any state supported scheme in Europe. It is for these reasons that I do not believe they can be classed as true hypochondriacs.

A hypochondriac is a strange creature—one suffering from hypochondria, which the dictionary defines as one with a persistent neurotic conviction that he is likely to become ill, and often experiences real pain, when illness is neither actually present nor likely. They're the ones that always feel bad when they feel good, because they just know they're going to feel worse when they feel better. They take drugs that haven't even been written up in *Reader's Digest* yet and have diseases that have no known cures. In fact, these diseases have no known names yet. They'll never die in their sleep because they never sleep that good, and they've taken so many different colored pills, all their dreams are in technicolor. I once knew one who had taken so many red and green pills that they used him during the rush hours to direct traffic. Just ask a hypo how he feels and he'll give you a preamble to his constitution. He's always on pills and needles and will never kiss a girl unless she has penicillin in her lipstick. He's probably taken so much penicillin himself that everytime he sneezes he cures a dozen people. One thing he won't take is tranquilizers because he gets agitated when he's not high strung. He'll break off his friendship with you if you ever send him a get well card, and he has made all the arrangements with his undertaker that he is not to be buried anywhere unless there is a doctor on the lot.

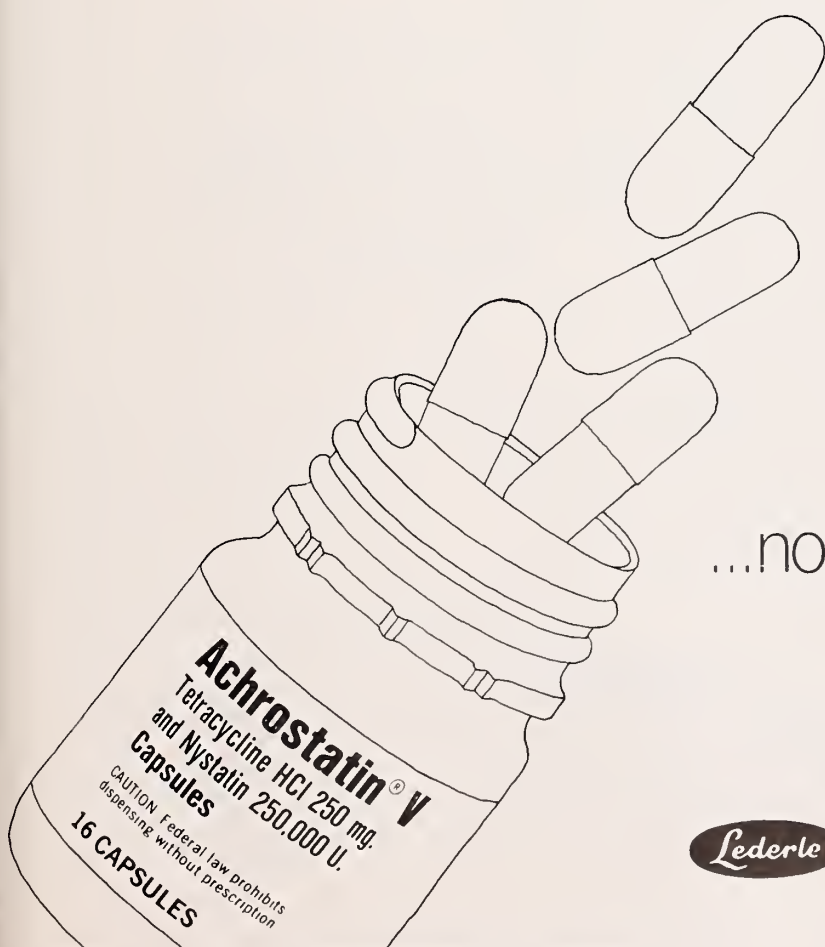
It appears these politicians are just not sure what they do want. They say the doctors are greedy, incompetent monsters, not capable of delivering the proper medical care to America, and that the plan they propose will correct all this. Just how naive can they be? They surely must know that the same group that they label greedy, incompetent monsters are the ones that will have to administer the medical care, regardless of whose plan is adopted.

At any rate, the President's freeze on the economy has put all plans in the cooler for the time being. But not for long, for the so-called missionaries for the little man will be back, screaming loud and long. Since it's hard to believe that they ingest their own output, and surely one must not believe that they are doing this to boost their own political power, it could be that either they don't like us, or maybe they are political hypochondriacs.

While you are thinking that over, I'll
See you next month.

W.C. Mitchell

*W. C. Mitchell, M.D.
President, Medical Association of Ga.*



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EXERCISE AND THE HEART

C. WALKER BEESON, II, M.D., *Savannah*

PHYSICAL EXERCISE produces both direct and reflex cardiovascular effects which may be both diagnostically and therapeutically useful. Exercise may be isometric (sustained contraction) or dynamic (rhythmic contractions). Isometric (static) exercise occurs in many common activities such as holding heavy objects and pushing against relatively immobile resistances. The mass of skeletal muscle involved in an isometric contraction is not so important as the fraction of the maximum contraction attained. A 50 per cent effort with a hand grip will have the same cardiovascular effect as a 50 per cent effort performed with the much larger muscle mass of the legs. Significant isometric effort results in a marked rise in mean arterial blood pressure with only modest increases in heart rate and cardiac output. The strength of individual muscle groups is improved by isometric training, whereas general cardiovascular efficiency is not affected by this type of exercise. Since isometric exercise produces little improvement in cardiovascular conditioning and since its pressor effects may be harmful, it has little place in treatment programs of patients with cardiovascular disease. The predictable pressor response, however, may prove to be a simple, noninvasive circulatory stress test useful for the evaluation of cardiac murmurs and left ventricular function.

Dynamic exercise occurs in most everyday activities as well as in such pursuits as jogging and cycling. Cardiac output and heart rate are significantly increased, usually with insignificant increases in mean blood pressure. A program of training will predictably improve general cardiac efficiency with a lower resting heart rate and a lower heart rate for any given degree of exercise. As heart rate is one of the primary determinants of myocardial oxygen consumption, dynamic exercise conditioning should lower both resting and exercise cardiac oxygen requirements. The efficiency of the respiratory apparatus, of skeletal muscle, and of certain metabolic activities is also improved during dynamic exercise training. Prudently designed exercise programs will aid most patients with angina pectoris by improving exercise tolerance. Similar programs are helpful in the rehabilitation of the patient who has recovered from a myocardial infarction. Whether these programs will improve life expectancy and reduce morbidity in coronary disease is not yet established. The quality of life for many patients is, however, undoubtedly improved.

Electrocardiographic exercise tests have been used for a number of years to assess the adequacy of the coronary circulation. The older two-step test has fallen into some disfavor because it does not accomplish a standardized stress for the heart; i.e. external work performed may not correlate well with cardiac oxygen requirements. Exercise tests have recently employed a target heart rate as a standardizing factor. As previously noted, heart rate is one of the chief determinants of the heart's oxygen needs, so similar degrees of cardioacceleration represent a reasonably standard stress for the heart. These exercise tests are continued until a certain percentage of the predicted heart rate based on the patient's age and sex is attained. Cardiac acceleration to approximately 85 per cent of maximal rate in-

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

dicates an adequate submaximal exercise test. The predicted maximal rate can be obtained from readily available charts. The type of exercise is not crucial, and bicycle ergometers, treadmills or step-ups can be used as facilities permit. Graded, dynamic exercise performed in this fashion permits the detection of: 1) the exercise tolerance of a cooperative patient and thereby an indirect assessment of that patient's cardiorespiratory function; 2) the electrocardiographic evidence (standardized ST segment abnormalities) of coronary insufficiency; and 3) the relation of the patient's symptoms (e.g. angina pectoris) to physical activity.

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THE PRICE OF AN UNWANTED BABY

JOHN L. MOORE, JR., *Atlanta**

MR. TROPPI, 43, and his wife, 37, had seven children ranging in age from six to 16 years. Mrs. Troppi lost her eighth child by a miscarriage. At that point she and her husband consulted with their physician and decided to limit the size of their family. The physician prescribed an oral contraceptive, Norinyl, as the most desirable means of insuring that Mrs. Troppi would bear no more children. He telephoned the prescription to Frank Scarf, a licensed pharmacist. Scarf negligently supplied Mrs. Troppi with a drug called Nardil, a mild tranquilizer. Mrs. Troppi loyally took the pills, thinking that they were contraceptives. However, within four months she was again pregnant. In due course she delivered a well-born son.

The Lawsuit

Mr. and Mrs. Troppi sued Dr. Scarf asking four separate items of damage: (1) Mrs. Troppi's lost wages; (2) medical and hospital expenses; (3) the pain and anxiety of pregnancy and childbirth; and (4) the economic cost of rearing the eighth child.

The trial judge dismissed the lawsuit, saying that whatever damage the plaintiff suffered was more than offset by the benefit to them of having a healthy child.

Decision of the Appellate Court

The Court of Appeals of Michigan declared otherwise. The court noted carefully that the pharmacist had been negligent in carrying through the high standard of care imposed on pharmacists in filling prescriptions. The only question was whether the bearing of a healthy child can be considered damaging to the child's parents.

The court brushed aside any argument that it would be against public policy to allow the plaintiff to have damages. It pointed out that the Supreme Court of the United States had given constitutional protection to the individual's right to use contraceptive methods contrary to the laws of a state of the United States. It pointed to acts of the Michigan Legislature authorizing the Health Department to give information concerning contraception as well as to distribute devices. It also pointed out that tens of millions of persons used contraceptives daily to avoid pregnancy, therefore making it clear that the public at least recognizes that it is appropriate not to want to bear children.

The court then approached the interesting question of whether there could be any damages. It reviewed all of the cases to date, usually cases involving defective sterilization, where courts had awarded damages for the birth of a healthy baby. The court recognized that there could be an argument in behalf of the pharmacist that the family received some benefit from the birth of a healthy child. For example, the child might have earnings which would inure to the benefit of his parents. Further, there is a psychological happiness of having the child. How-

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to the Association.

ever, the court said that these items are merely items to be used by the jury in setting the amount of the verdict.

The court very clearly said that it was not necessary for the Troppies to mitigate damages by having an abortion or by placing the child for adoption. These items were specifically not to be taken into consideration by a jury in considering the proper amount to award against the pharmacist.

The court then considered the interesting question of whether there might be varying degrees of detriment to persons in different positions, in having an unwanted child. The following language from the court's opinion is most interesting:

"Consider, for example, the case of the unwed college student who becomes pregnant due to a pharmacist's failure to fill properly her prescription for oral contraceptives. Is it not likely that she has suffered far greater damage than the young newlywed who, although her pregnancy arose from the same sort of negligence, had planned the use of contraceptives only temporarily, say, while she and her husband took an extended honeymoon trip?

Application of the benefits rule permits a trier of fact to find that the birth of a child has materially benefited the newly-wed couple, notwithstanding the inconvenience of an interrupted honeymoon, and to reduce the net damage award accordingly. Presumably a trier of fact would find that the 'family interest' of the unmarried coed had been enhanced very little.

The essential point, of course, is that the trier must have the power to evaluate the benefit according to all the circumstances of the case presented. Family size, family income, age of the parents, and marital status are some, but not all, the factors which the trier must consider in determining the extent to which the birth of a particular child represents a benefit to its parents. That the benefit so conferred and calculated will vary widely from case to case is inevitable."

Comment

As indicated above in the article, several jurisdictions, including North Dakota, California, Florida, and West Virginia, have held that parents of an unwanted child could recover damages after a defective sterilization procedure. It will be interesting to see whether damages may be awarded against physicians who decline to perform a requested abortion, assuming the Supreme Court of the United States eventually determines that the law of the land is liberal as to abortions. To date the writer knows of no Georgia decision in this field. Therefore, it will be interesting to see how the law develops in Georgia.*

* The case discussed is *Troppi v. Scarf*, — Mich. —, 187 N.W. 2d 511 (Ct.App.Mich. 1971).

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SOCIETIES

The Savannah Benevolent Society has given the **Georgia Medical Society** \$6,000 to purchase a Rocom multi-media instruction system to train coronary care personnel in the community.

PERSONALS

Seventh District

John I. Dickinson of Rome was guest speaker at a meeting of the Gordon County Unit of the American Cancer Society in August.

Don Schmidt of Cedartown has been named a charter diplomate of the American Board of Family Practice.

Eighth District

Eugene D. Bell of Douglas has been named a charter diplomate of the American Board of Family Practice.

Ohlen Rudolph Wilson of Alma has been named a charter diplomate of the American Board of Family Practice.

DEATHS

William W. Aiken

William W. Aiken of Lyons died August 9 in St. Joseph's Hospital, Savannah. He was 68 years old.

A graduate of Emory University School of Medicine, he served as house surgeon for St. Joseph's Hospital in Atlanta for two years before beginning his practice in Lyons in 1929.

Dr. Aiken operated one of the first private hospitals in that area and later formed a partnership with Dr. J. D. McArthur to establish the Aiken McArthur Hospital.

He was a member, past president and past secretary of the Southern Medical Association. He was a member of the Vidalia Golf Club, the Lyons Kiwanis Club and the Vidalia Elks Club. He had also served for a number of years on the board of stewards of the Methodist Church in Lyons.

Dr. Aiken is survived by his widow, Mrs. Parepa Travis Aiken; a son, William T. Aiken; four grandchildren, Will, Etta, Bob and Drew, all of Lyons; three stepsons, William Travis of Covington, Robert Travis of Athens and John Travis of Lyons, and a sister, Miss Julia Aiken of Covington.

Conway Walter Hunter, Sr.

Conway Walter Hunter, Sr., an Atlanta physician for more than 50 years, died September 7 in a private hospital.

Born in Columbus, Ga., he was a graduate of old Boys' High School in Atlanta. He was graduated from the University of Georgia and Emory University Medical School, and served with Emory's Medical Unit in France and Mexico during World War I.

Dr. Hunter was a member of the Medical Association of Atlanta, Medical Association of Georgia, Southern Surgical Society and the American College of Obstetricians and Gynecologists. He was on the staff of St. Joseph's Infirmary and Crawford W. Long Hospital.

Dr. Hunter was a charter member of Druid Hills Baptist Church and Peachtree Lodge 732, F&AM and was a member of the Yaarab Temple, the Royal Order of Jesters, Phi Chi Alpha social fraternity and Phi Chi medical fraternity.

He is survived by his widow, a daughter, a son, three sisters and a brother.

UTILIZATION REVIEW TRAINING INSTITUTE

In the fall of 1970, the Hospital Utilization Project of Pittsburgh was awarded a 19-month contract with the United States Public Health Service to develop and implement a nationwide Utilization Review Training Institute.

The Institute training sessions are intended to provide a clear and full understanding of the concepts of Utilization review, methods of operation, and its educational value in the provision of health care.

Participants are supervisory and consultant health staff in Community Health Service, Bureau of Health Insurance, Medical Services Administration, and National Institutes of Mental Health central and regional offices, and state and local health agencies, who can serve as trainers in their agencies; state agency surveyors; fiscal intermediary personnel dealing with Utilization Review; and provider personnel and medical staffs.

In planning the Institute, the Hospital Utilization Project of Western Pennsylvania will have the cooperation of the Program in Medical and Hospital Administration of the University of Pittsburgh Graduate School of Public Health.

Aims and Objectives

The syllabus for the Utilization Review Training Institute has been prepared in an effort to provide those who use it with a guide for conducting an institute of their own. The content deals with a number of concerns such as greater understanding of the concept of utilization review, methods of operation, and the educational value of utilization review in the provision of health care. A number of broad areas of concern were considered as the main aspects of the curriculum. The core of the curriculum deals with these.

In the syllabus the user is provided with selected guidelines for using training techniques and methodology appropriate to particular areas of the curriculum. Also provided is enough substantive content that will serve to deal with each topical category covered in the syllabus. Another feature of the syllabus is a supplementary package of materials to back up the content areas, and to provide those who use them, additional useful information. Enough bibliographic reference is included for those who wish to seek greater depth regarding some of the educational techniques outlined here and the content material discussed. The syllabus contains a glossary of health oriented terms so that concepts can be dealt with that will serve as a common base for conducting training institutes in the future. Even if there is some disagreement with particular terms, a common base of understanding can be built from any term as presented if only by using it as a point of departure. It is quite important that those who come together for a training session speak and understand the same language.

An important feature of the syllabus aims at providing a clear, concise and complete program for the conduct of an institute with any group involved in delivery of health services and in some way concerned with the concept of utilization review. The level of the presentation can be geared in a practical way to those

in the audience. There is opportunity provided on which to build a common base of understanding related to the conceptual level existing within the participant group at the time of the training program. For example, if this is a physician group, obviously they will already be familiar with medical aspects related to utilization review to a greater degree than a group not so versed in this area. Other elements are treated in a similar way, thus the level of presentation can be geared meaningfully to the participant's needs.

Objectives

There are several levels of objectives. One level provides the overall objective of a session. Along with this, there is a description of a session so that the learner as well as the trainer understands what goal is to be achieved and how this might be accomplished. In addition, various techniques are described that help make it possible to achieve the objective as stated. The overall training objective remains constant, that being to repeat the training process so that others may understand the content in principle and application as well as the techniques used for presentation.

The focus of this program as outlined in the syllabus covers several broad concerns in general terms. It is not meant in any way to convey that those who attend an institute will come away with finished skills that never existed in the past. The syllabus provides the means for building on previous knowledge and also the means for providing some added experiences to help clarify existing confusion or concern. To this end, a program is presented that deals with the following:

1. Objectives of the Utilization Review Training Institute and discussion of the history, concept and rationale for utilization review.
2. Development of an understanding of the inter-relationship of responsibilities in achieving utilization review objectives with focus on interests and concerns of the federal government, state agencies, third party payers, providers and others.
3. Development of an understanding of the application of routine and special data to utilization review.
4. Demonstration of techniques in utilization review to develop broader understanding of problems and ways to deal with them in the field.
5. Techniques of utilization review with focus on problem solving.
6. Discussion of future developments and how these will affect the future of utilization review activities.
7. Development of an understanding of motivational aspects aimed at stimulating motivation for achieving change in current utilization review practices.
8. Participant evaluation of the training institute.

Materials

Resource materials, instructions, guidelines and sufficient content are included in the syllabus so that the package contains the necessary elements for anyone interested in conducting a training institute. For example, in the session on the techniques of utilization review, an entire kit called the Utilization Review Committee in Action is provided and includes everything from an

audio recording of a committee in action, a script to follow the audio with indications where the audio should be interrupted with discussions to be held to cover specified points, a summary of a special study, minutes of the previous meeting, and details for discussion of the items where the audio portion is stopped.

Materials are included which provide practical problems in application of data as well as other forms of aids for problem solving. These include case examples of utilization review related problems encountered in the field. These are cases selected from actual experiences provided by State agencies and others in response to the Utilization Review Training Institute's request. The Institute has also developed a case book which can be used separately as a training guide and/or field manual and will cover 12 categories of problems.

Conclusion

Because of the great emphasis that has been put on utilization review through the activities of hospital utilization review committees, medical society peer review committees and Medical Care Foundation activities, participation in an Institute such as this would prove of great benefit to physicians, regardless of their current level of concern with utilization review. For additional information on the Utilization Review Training Institute, interested individuals should write directly to the Institute: Utilization Review Training Institute, 3530 Forbes Avenue, Pittsburgh, Pennsylvania 15213.

For those interested in participating in such a training institute locally, the MAG staff will attempt to assist in the development of such programs. Interested individuals should write to: Project Director, EMCRO, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

THE MONTH IN WASHINGTON

The American Medical Association supported President Nixon's legislation to create a special White House office to coordinate the federal government's fight against drug abuse "as an important element of the national campaign."

The AMA support was outlined by Dr. Maurice H. Seevers, chairman of the department of Pharmacology at the University of Michigan and a member of the AMA Committee on Alcoholism and Drug Dependence, before the House Public Health and Environment Subcommittee. He was accompanied by Dr. Richard E. Palmer, a member of the AMA Board of Trustees.

Dr. Seevers said that "under Dr. Jerome Jaffe's able direction the (White House) Special Action Office can become a most effective instrument" in achieving the purpose of the legislation:

"... to focus the comprehensive resources of the federal government and bring them to bear on drug addiction and drug abuse with the immediate objective of promptly and significantly reducing the incidence of drug addiction and drug abuse in the nation within the shortest possible period of time."

Other Observations

"We have two additional observations regarding this stated objective," Dr. Seevers said. "First, although prompt and decisive action is to be desired as a goal, it should be clearly recognized that there are no panaceas for the prevention or successful treatment of drug dependence. Drug dependence is a complex phenomenon that does not lend itself to quick or simplistic solutions.

"Our second observation is related to that fact: Well-conceived multi-faceted research is needed on a broad scale to devise effective means of coping with this problem.

"With respect to the drugs themselves, while much is known about their properties, relatively little is known about their precise mode of action in the hu-

man organism and the exact nature of the long-term effects of their regular use by man.

"While some of the factors which lead individuals to abuse drugs are understood, science is not yet able to predict who may be vulnerable to drug dependence. The role of drug abuse within the context of a total life style also needs to be more clearly delineated.

Work Needed

"Much work remains to be done in developing new, and evaluating existing, treatment methods in terms of the therapeutic needs and psychosocial makeup of the individual patient. Physicians can treat the acute effects of drug abuse and drug dependence, often preventing serious physical and psychological consequences; but medical and sociological management techniques have not been developed so as to insure that a significant number of patients will not return to abuse of drugs and to their patterns of dependence after the acute symptoms have been abated through treatment.

"Methods of 'reaching out' to the young drug abuser must be tested to ascertain the most effective courses that educators, physicians and those in other professions can pursue.

"Finally, a great deal more work should be carried out with human subjects. Especially needed are longitudinal studies encompassing etiology, diagnosis, treatment and after-care, even though such studies would require an extended period of years."

Dr. Seevers cautioned that "the technique of treating heroin dependence through methadone maintenance, although offering hope and the possibility of social rehabilitation to a number of dependent persons, is but one of several modalities which can be useful."

Legislation Record

The American Medical Association set forth its recent record on legislation—a record that shows statements in support of health care proposals in 31 of 35

appearances in the 91st Congress and support in the present Congress for medical school expansion, increased financial aid to medical students, family practice training programs and full funding for maternal and child care programs.

"It requires a certain strain on the process on human logic to interpret this record as negative," the AMA stated.

The AMA's record on legislation was submitted as part of a 39-page statement filed by the organization with the Subcommittee on Administrative Practice and Procedure of the Senate Judiciary Committee. Subcommittee Chairman Sen. Edward M. Kennedy (D.-Mass.) had charged the AMA with maintaining a negative and obstructionist attitude toward proposals to improve health care in the United States during a hearing by the subcommittee on July 14.

Bill Position

Bills supported by the AMA in the 91st Congress included appropriations for hospital and medical facilities construction, appropriations for medical education, drug abuse education and narcotic addict rehabilitation, vaccination assistance programs and regional medical programs.

The AMA opposed as unnecessary the proposed Commission on Marihuana; opposed one version of the Occupational Safety and Health Act of 1969 but supported another version in both the Senate and House; and opposed certain parts of the Social Security Amendments of 1970 while supporting other parts of the bill.

This affirmative legislative stance has been maintained in the present Congress, as many members of the Senate and House from both sides of the aisle will attest, the AMA noted.

Medicredit

The AMA, in its statement, pointed out that it has introduced its own proposal for financing health care—Medicredit—which would provide government subsidized health insurance to the poor and insure against catastrophic medical costs.

"Medicredit is designed to end for all Americans the burden of expense, and to make all Americans truly equal in their access to all types of medical care," the AMA said.

AMA Warning

The organization warned against the "panacea" approach of a massive government health program as recommended by Kennedy.

"We have learned that lesson in welfare and poverty," the AMA said. "Must we learn it anew with health care?"

Regarding specific charges leveled against the organization and doctors generally by Kennedy, the AMA statement termed them "out of date, out of context, and out of balance."

"And his conclusion, that doctors act primarily for gain, is outrageous," the AMA report stated.

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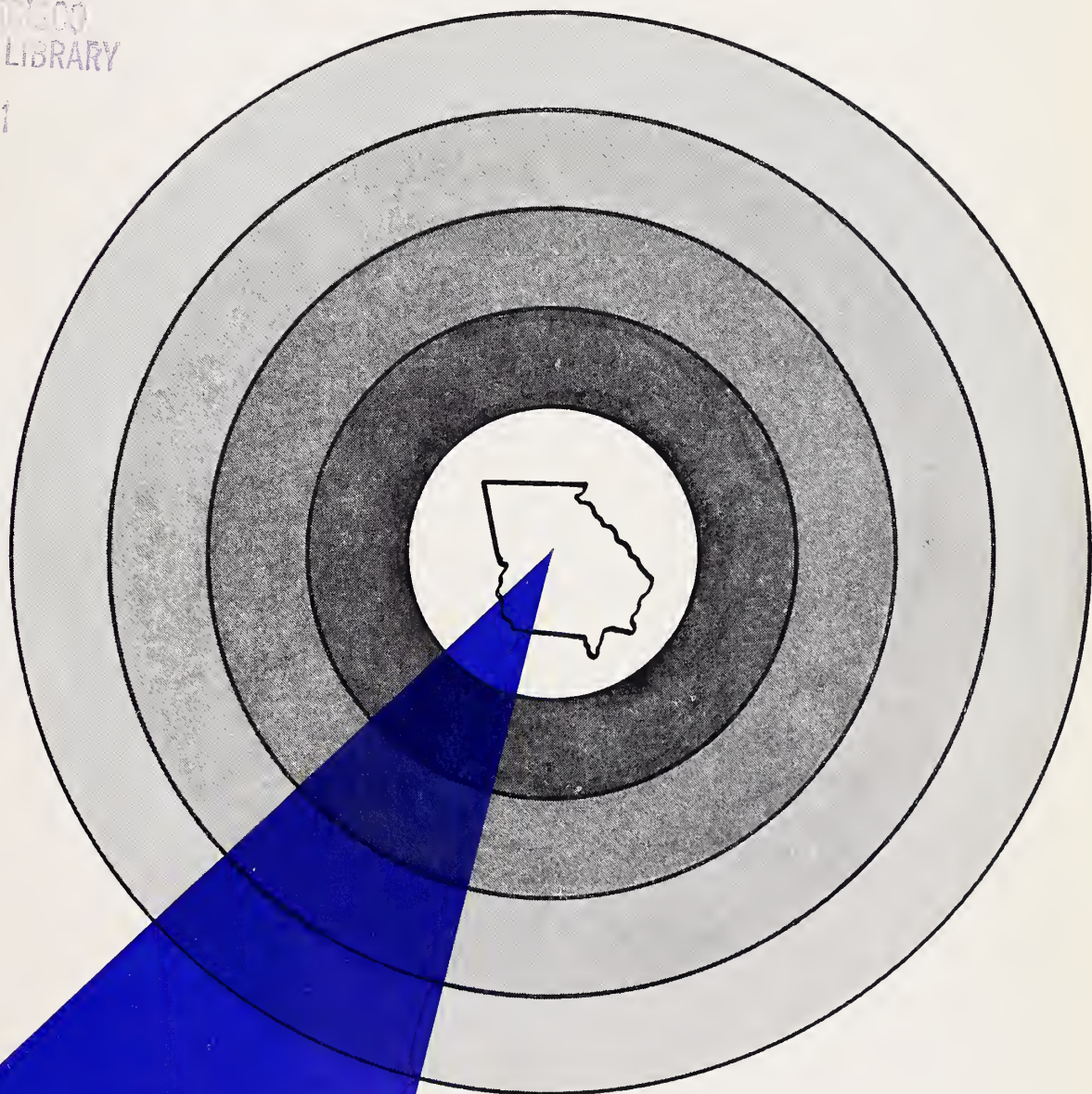
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GRMP : **A** **HISTORY**

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Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electroencephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

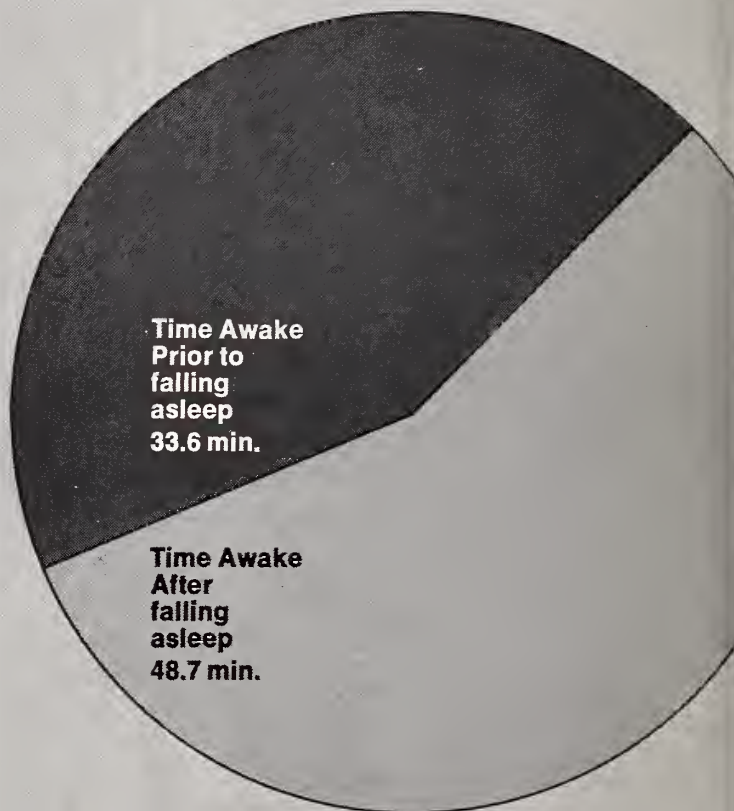
Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

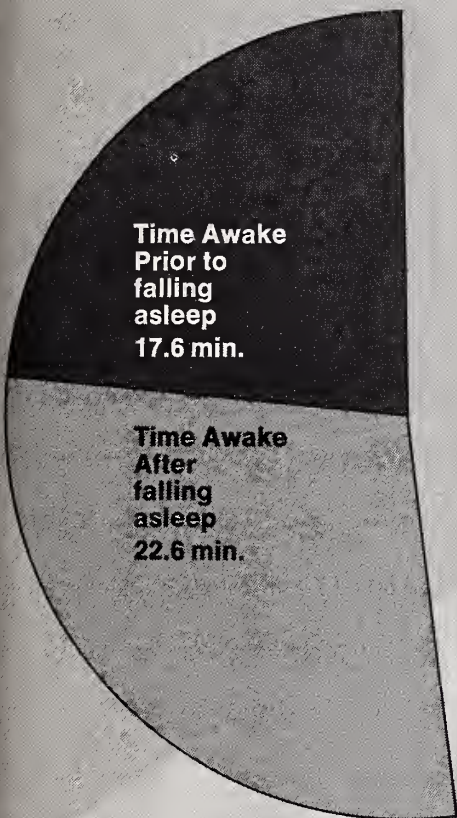
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

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time after onset of sleep	48.7 min.	22.6 min.
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total sleep percent	88.6	94.5

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Design by Nancy Hull, Georgia Regional Medical Program. Layout by Robert Hamill, Atlanta.

The Georgia Regional Medical Program

J. GORDON BARROW, M.D., *Atlanta*

DURING ITS FIRST three years of operation, the Georgia Regional Medical Program, through the efforts of its Regional Advisory Group, Steering Committee, Local Advisory Groups, and Task Forces, established a goal, objectives, and priorities and developed a program to meet these goals. At the same time the staff evolved planning, development, operating, and assessment capabilities and procedures to assure effective program management.

The Regional Medical Programs Service in Washington and the RMP National Advisory Council noted these accomplishments, among others, as they reviewed the GRMP Second Triennium Application this summer, using a newly instituted process that allows the delegation of program management and technical project responsibility to the individual RMP's. The new award process incorporates a selective funding approach, which calls for weighted rating on a number of criteria. This permits variable funding awards based on the past performance and demonstrated potential of the applicant RMP.

Thirteen RMP's were included in the review cycle that employed the first test of this system, and GRMP earned the highest score, thus winning an increased overall funding level for the three-year period beginning September 1, 1971. In addition, GRMP became one of the first RMPs to be awarded a sum of money called a "developmental component." These funds are specifically approved for expenditure on local GRMP authority with Washington review not required, and the GRMP Regional Advisory Group has decided that this developmental component should be directed primarily

ly to supporting efforts to solve health problems of the urban and rural poor.

Allocation of GRMP grant funds for this year was made by the Regional Advisory Group at its meeting in Atlanta on August 29, 1971, just three days after notification of the award. The funding for this year is \$1,779,862, an amount equal to last year's funding, following the RMP plan to distribute monies based on last year levels until the Office of Management & Budget determines how much additional funds—which have already been appropriated by Congress—will be released to the RMP. If and when more funds are released, GRMP will likely receive a portion, since the National Advisory Council of RMP has approved a GRMP level of funding for this year of \$2,906,290, providing the money becomes available.

In addition to the \$1,779,862 actually awarded, GRMP has been given \$177,986 for the developmental component. This will encourage and permit rapid response to newly identified opportunities for assisting providers of care in efforts to improve health services, without delaying support until the next annual budget cycle.

New RAG officers elected and installed at the August meeting are Roy J. Weinzettel, Savannah, Chairman; A. H. Letton, M.D., Atlanta, Vice-Chairman; and Louis C. Brown, M.D., Atlanta, Secretary.

The RMP National Scene

Meeting in Atlanta in March of this year, RMP Directors from all over the country developed a position paper that outlined ways in which RMP's can play an important role in addressing key features of the President's Health Message. The paper covered RMP contributions, both past and potential, in the areas of 1) working with health professionals in the demonstration and promotion of new techniques for improving the efficiency and effectiveness of health care, 2) the establishment of a series of new Area Health Education Centers as recommended by the Carnegie Commission on

Editor's Note: J. Gordon Barrow, M.D., has directed the Georgia Regional Medical Program since its beginning in 1967. For the past year, he has served as Chairman of the National Steering Committee of Coordinators, a group comprised of directors of the 55 RMPs. In this position, he has contributed to the continued growth of RMP as a federally funded health program whose success is achieved through assisting health care providers, under the guidance of locally established and directed policy making bodies. Dr. Barrow is also serving his second term as Chairman of the Southeast RMPs, an affiliation of 14 RMPs who work together on matters of mutual interest and concern, exchanging information and developing problem solutions. The Coordinator of GRMP for the Medical Association of Georgia, which is the fiscal agent that receives and disburses RMP funds, is M. C. Adair, M.D.

Higher Education, 3) assisting providers in their efforts to improve accessibility of health care, 4) the Emergency Health Personnel Act, 5) assisting groups interested in developing health maintenance organizations, and 6) the health manpower crisis.

Secretary of HEW Elliot Richardson discussed this position paper in his Washington office with a group of RMP representatives led by Dr. Harold Margulies, RMP Director. From this meeting, there came a new Administration awareness of RMP's built-in capacity to work with the private health sector to bring about change in health care delivery and manpower. "RMP may be the key around which all these interests pivot," according to Dr. Margulies, who noted that those words were not his own but those of HEW Secretary Richardson.

Dr. Margulies observed "The implementation and experience of RMP over the past five years, coupled with the broadening of the initial concept especially as reflected in the most recent legislative extension, has clarified the operational premise on which it is based—namely, that the providers of care in the private sector, given the opportunities, have both the innate capacity and the will to provide quality care to all Americans.

"Thus," said Dr. Margulies, "RMP may be characterized as a framework within which all providers can come together to meet health needs that cannot be met by individual practitioners, health professionals, hospitals and other institutions acting alone. The structure is deliberately designed to take into account local resources, patterns of practice and referrals, and needs, and is therefore a potentially important force for assisting providers of care as they seek to improve personal health services throughout the Nation."

From the start, GRMP has followed a "program approach" to develop and implement a coordinated, comprehensive program of related projects in three program areas. These areas correspond to the three GRMP objectives, and are the Categorical Diseases (combining heart, cancer, stroke, kidney disease and related diseases), Continuing Education & Health Manpower, and Facilities & Services.

In its triennial report to RMP this summer, the GRMP Regional Advisory Group stated "From its inception, GRMP has adhered to the principle that the broad program must be planned prior to the implementation of individual projects. Each of the Task Forces developed its own program priorities and strategy for achieving these program goals prior to any project application being accepted or reviewed.

"Every project proposal, therefore, is looked at in terms of how well it meets the goals, objectives and priorities established previously by each Task Force. This has allowed us from the beginning to implement only those projects which promised to have broad program implications. As a result, many of our projects interrelate and depend upon one another since they are all interwoven in a planned approach to total program."

Task Force Responsibilities

GRMP Task Forces operated initially as study groups with broad representation from throughout Georgia, and they prepared position papers identifying needs, problems and available resources. Using these papers as background, the study groups then established goals, objectives, priorities and program strategies in their particular topic area. This work was then discussed and approved by the GRMP Steering Committee and Regional Advisory

GRMP GOAL AND OBJECTIVES*

The overall goal of the Georgia Regional Medical Program is to improve regional health resources and enhance the capabilities of providers of care at the community level in a way that will influence present arrangements for personal health services to permit maximum availability, accessibility, and use of the best in modern medical care for heart disease, cancer, stroke, kidney disease and related diseases.

Specific objectives:

- To increase the availability and efficiency of health manpower in Georgia
- To improve the quality of medical care in Georgia, including prevention, diagnosis, treatment and rehabilitation
- To improve the availability and accessibility of primary medical care and of specialized diagnostic, prevention, treatment, and rehabilitative services to all persons in Georgia

** Unanimously reaffirmed by the GRMP Regional Advisory Group April 23, 1971.*

GRMP REGIONAL ADVISORY GROUP STEERING COMMITTEE

R. J. Weinzettel, Chairman, Savannah
Louis L. Battey, M.D., Augusta
Robert L. Brown, M.D., Atlanta
J. B. Ellison, M.D., Atlanta
J. Willis Hurst, M.D., Atlanta
A. J. Bollet, M.D., Augusta
M. C. Adair, M.D. (ex officio), Washington

Group, and became the foundation upon which GRMP was built.

Today, GRMP Task Forces have new responsibilities. In addition to maintaining an awareness of changing problems and needs so they may develop new strategies as appropriate, the Task Forces serve as technical review groups for GRMP. They review every project proposal submitted for funding to 1) determine the overall importance of the proposal to the particular program part of GRMP for which that particular Task Force is responsible, and 2) assess the technical adequacy of the proposal.

Basic to the GRMP approach is the "area facility concept," which grew out of separate but similar strategies developed independently by the various Task Forces. This concept revolves around the support of selected community hospitals to help them expand and extend services to surrounding areas. Area facilities have specialized personnel and facilities—the nature of which depends on the kind(s) of orientation selected, e.g. cardiovascular, stroke, continuing education, etc.—and they are encouraged to develop and use relationships with other community hospitals as means of extending services. Some may be affiliated directly with a medical school, but most are not.

The First Three Years—A Summary

The following summary of the operational period just past is provided as background to the outline of activities that GRMP is supporting in the first year of its new triennium. Because space limitations have necessitated only brief summaries, your inquiry is invited for further information on any of the projects listed in which you may have a further interest:

CONTINUING EDUCATION & HEALTH MANPOWER PROGRAM

Clinical Training Conferences for Health Professionals. Individually designed postgraduate courses were provided at Emory University and at the Medical College of Georgia, responsive to specific needs of physicians who indicated a desire to

develop new skills. A total of 81 physicians completed 358 days of training at the schools.

Post-Residency Traineeships. This project provided three post-residency traineeships, two in pediatric cardiology (one each at Emory University and the Medical College of Georgia) and one in hypertension-renal disease.

Visiting Consultants to Community Hospitals. This project made available visiting consultants to GRMP supported area facilities and to other community hospitals throughout Georgia, using faculty from Emory and MCG, as well as private practitioners. Topics ranged over a wide spectrum, from medical problems of the categorical diseases to in-service education procedures. During the reporting period, 153 visits were made by consultants, resulting in 2,370 physician contacts, 799 registered nurse contacts, 714 allied health personnel contacts and 168 dentist contacts.

Interlibrary Copying Service. More than 25,000 pages of materials were provided through this service, which is now continuing through the Southeastern Regional Medical Library Program, without further funding support from GRMP.

Columbus-Emory Teaching Affiliation. This project contributed to the development of an affiliation between Emory University School of Medicine and The Medical Center, Columbus. During this project period, a total of 21 Columbus physicians were appointed to the Emory medical faculty, with the understanding that they spend at least two weeks in training each year at Emory. These faculty physicians are, in turn, committed to teaching roles in Columbus for interns, residents, other physicians, nurses, and allied health professionals.

A Communications Network for the Region. This project, in which Emory and MCG participated, supported production and broadcast of 1100 programs (900 hours) on the Metro Network and 28 additional one hour programs over public TV throughout the region. The 39 hospitals on the Georgia Regional Medical Television Statewide Network each have continuing education programs. Statewide Educational TV broadcasts were discontinued in December 1970, in favor of distribution of project programs through a tape lending library administered by the A. W. Calhoun Medical Library of Emory.

Training for Medical Specialty Assistants. This project evolved in 1969 to one designed for creating individuals highly skilled within the areas of medical intensive, coronary, respiratory, and emergency care. A major accomplishment during the year just past is the progress made toward developing the training program as a course of study within the Emory University School of Medicine's Division of Allied Health Professions. The first four

GRMP / Barrow

graduates of the program include one working in Hall County Hospital and two at Grady Hospital. Another is employed as assistant to the Chief of Medicine at The Medical Center, Columbus, with primary responsibilities in the areas of cardiac rehabilitation, exercise testing, and hypertension clinic (he is a member of the GRMP-supported area facility at The Medical Center).

Area Facilities for Continuing Education. Four community hospitals have been funded, each with part-time physician direction and a full-time nurse/allied health coordinator: Athens General Hospital; The Medical Center, Columbus; Memorial Medical Center, Savannah; and The Medical Center of Central Georgia, Macon. They have assisted surrounding community hospitals in their development of programs of continuing education for all health professionals.

System of Coronary Care Training. Intensive training was provided for 186 registered nurses. The Atlanta Medical Center conducted sessions for four-week periods (five days a week for a total of 20 days), training 102 registered nurses. Archbold Hospital in Thomasville conducted a ten-week program consisting of 10 one-day sessions, training 84 registered nurses from smaller hospitals in south Georgia.

Physiology for Nurse Instructors & Practitioners. Instruction in cardiovascular physiology was provided at Emory University for 26 nursing instructors through three separate courses, with participants from 11 states.

Physical Therapy Feasibility Study. Three counties in northeast Georgia and five in southeast Georgia had no physical therapists prior to this project. GRMP assisted in the recruitment of a physical therapist and the development of a cooperative arrangement so that the services of these professionals could be shared by several institutions on an equitable basis. As soon as the physical therapists became self-supporting, GRMP funds were withdrawn and reallocated.

CATEGORICAL DISEASES PROGRAM

Statewide Cancer Program. To improve the distribution and quality of care for cancer patients, 12 area cancer facilities—each with a tumor registry—were established and operated, each with a part-time medical director and a full-time registry secretary. Tumor registries now have detailed information on more than 23,000 patients. Tumor conference participation at the area cancer facilities almost doubled from 1967 to the past year, and workshops and training conferences for allied health personnel involved more than 600 nurses, radiotherapy technicians, and tumor registrars. Ten can-

cer workshops for physicians, held at locations around the state, drew more than 400 doctors.

Cardiopulmonary Resuscitation Program. In cooperation with the Georgia Heart Association, a cadre of instructors within the organizational structure of the community hospitals was trained in order to encourage the establishment of ongoing training activities in their communities. A total of 2,665 CPR instructors were trained, covering 120 counties in Georgia, an area in which 93 per cent of the population lives.

Community Hypertension Program. During the first year of this project, it was found that high blood pressure is an extremely common condition in the Atlanta community where the effort was focussed. Some 11,000 people were screened, and more than one-fourth of all the adults interviewed were hypertensive, with many unaware they had high blood pressure.

Cardiovascular Area Facilities. Five community hospitals have been funded: the Atlanta Medical Center; The University Hospital, Augusta; The Columbus Medical Center; Memorial Medical Center, Savannah; and Athens General Hospital. These are providing specialized services for surrounding community hospitals.

Regional Pediatric Respiratory Center. Congress earmarked certain RMP funds during the first triennium for these Centers around the country, and the Medical College of Georgia was one chosen. Due in large measure to initial GRMP support, MCG now has four full-time faculty members with in-depth knowledge in the area of respiratory illness in children. During a sample reporting period (eight months ending March 1971) 552 patients from 73 Georgia counties were seen—a total of 2,432 outpatient visits. On- and off-campus education for physicians involved 92 doctors in five separate meetings and workshops during the past year. A clinical training program for nurses was also initiated.

Education and Service Program in Chronic Pulmonary Diseases in Northeast Georgia. With GRMP support, Athens General Hospital developed a cooperative arrangement with eight nearby hospitals to provide training and supervision of inhalation therapy services at those hospitals. Twenty-five trainees received 18-week courses and continuing supervision and the Athens registered inhalation therapist made 81 visits to the participating hospitals. As a result of this project, four of the hospitals have purchased new inhalation therapy equipment and five have organized a department of inhalation therapy. A total of 11,399 patient treatments was given under this project.

Renal Failure Training & Demonstration Program—Medical College of Georgia. Two patients

completed home dialysis training and three more entered training. Training manuals were prepared for dialysis equipment and 428 explanatory notes were sent from the kidney disease section outpatient clinics to 105 referring physicians in 58 Georgia towns and cities—these clinical notes provided a continuing education function built around a patient in whose problem the practitioner already had a very real interest.

Teaching, Training, & Demonstration Program in Hypertension & Nephrology—Emory University. In addition to liaison with vocational rehabilitation, this project provided training for 29 patient-family teams for home dialysis, 35 nurses, 13 technicians, 3 dietetic aides, 2 social workers, and 3 graduate fellows in post-doctoral training. Training manuals and curriculum were developed, and on-site visits about home dialysis were made to professionals in Gainesville, Savannah, Dublin, Athens, Columbus, and Macon. The project served 132 patients on chronic hemodialysis, 19 kidney transplants, sent 27 kidneys out of state, and treated patients from five adjacent states.

Stroke Area Facilities. Funding limitations permitted the initiation of only one stroke area facility during this period, Candler General Hospital at Savannah, funded beginning January 1, 1971.

Cardiovascular Diagnostic Service. Support from this project improved the equipment at the cardiovascular laboratories at five centers, greatly enhancing their capability and allowing them to provide cardiac catheterization, angiocardiology and coronary angiography to the other hospitals in the state. These diagnostic laboratories are located at Emory, Grady, and St. Joseph's in Atlanta; the Memorial Medical Center in Savannah; and the Talmadge Memorial in Augusta.

Coronary Intensive Care Development. This project was designed to help provide appropriate consultation for small hospitals through the transmission of monitored ECG's by special telephone line to the nearest medical center with a coronary care unit with trained staff. A total of 279 patients was monitored. Hospitals involved included Tanner Memorial, Carrollton; R. T. Jones Memorial, Canton; Evans County Hospital, Claxton; Hart County Hospital, Hartwell; Peach County Hospital, Fort Valley; Wayne County Hospital, Jesup; Habersham County Hospital, Demorest; Grady; Georgia Baptist; Glynn-Brunswick; and Talmadge Memorial, Augusta. These activities are all now self-supporting.

GRMP Program for the Second Triennium

With RAG allocation of funding for the fourth year of overall operation, there is continued commitment to the GRMP program approach. A number of carryover projects, most with significant re-

GRMP TASK FORCES AND CHAIRMEN*

Cardiovascular Diseases, Hypertension, & Diabetes

Charles R. Hatcher, M.D., Atlanta

Cancer

John D. Watson, Jr., M.D., Columbus

Stroke & Renal

Samuel B. Chyatte, M.D., Atlanta

Chronic Respiratory

Walter S. Dunbar, M.D., Atlanta

Continuing Education & Health Manpower

William B. Fackler, Jr., M.D., LaGrange

Facilities & Services

Douglas B. Kendrick, Jr., M.D., Atlanta

* Each Task Force has 12 members—Four practicing physicians, four non-physicians, and four medical school representatives (two each from Emory University and the Medical College of Georgia). Two members of each Task Force are also members of the Regional Advisory Group.

visions in objectives but building on the foundation of past efforts, will merge with several new activities as GRMP moves to respond to Georgia needs.

The GRMP developmental component funding mechanism has enabled rapid response to several ideas for exploratory approaches to assisting providers in solving problems of health services delivery. Task Forces have approved a number of these for preparation of formal applications for funding, with the first awards anticipated to be made sometime in December, 1971.

An important framework of the program, the area facilities, will be continued. New invitations to apply have been sent to present facilities and other eligible community hospitals and applications are now in the process of formal proposal development. The RAG has reaffirmed support for this concept and funding allocation among types of area facilities (cancer, cardiovascular, continuing education, and stroke) was made in August. September meetings of the GRMP Task Forces were devoted to establishing updated criteria for selection of applicant hospitals for funding. The review and selection process is moving toward Steering Committee final selections, with funds scheduled to be awarded to those chosen December 1, 1971.

As the area facility programs move toward implementation, a special feature is being prepared for the area facilities for continuing education. Following previous long term GRMP support for the establishment of the Georgia Regional Medical Television Network—and to help community hospitals take advantage of the continuing benefits of medical educational TV programs—a program of matching support is under development. Through this mechanism, GRMP will contribute matching

funds where community hospitals around the state wish to arrange to take continuing advantage of the GRMT Network at Emory University.

A decision has not been received, as of the time of this report, on the GRMP application for continuation of an expanded kidney disease program for Georgia. That portion of the triennium application was processed separately by RMP, with a special site-visit team coming to Georgia, and final notification is expected shortly.

In addition to the area facilities that will be a key part of this year's program, the following projects are being implemented:

CONTINUING EDUCATION & HEALTH MANPOWER PROGRAM

Clinical Training Conferences. This project continues from last year, expanded now to provide opportunities for both nurses and allied health professionals—as well as physicians—to acquire new skills through training at medical schools, teaching hospitals, and other institutions.

Visiting Consultants. This effort will continue as an integral part of the GRMP program, with its special contribution to the area facilities for continuing education, making available, on request, consultants to providers of health care from medical and nursing school faculties and through other health professionals in private practice.

Continuing Education Program in Nursing. This project is directed to an expansion of the potential of the Medical College of Georgia School of Nursing program for upgrading patient care by developing new skills in nurses throughout Georgia through continuing education.

Shared Allied Health Services. This project grew out of the successful physical therapy feasibility project undertaken last year, and seeks to continue that success by encouraging the provision of this and other types of allied health services to parts of Georgia whose patients do not now receive the full breadth of potential services because of a lack of skilled health manpower.

Health Career Counseling to Disadvantaged Students. Through a pilot program that involves 10 selected high school counselors around the state, this project will acquaint 100 high school students with existing needs for medical and allied health personnel, and attempt to assist them in pursuing health careers. The students chosen will receive intensive counseling, and will have an opportunity to relate to practicing physicians and other health professionals in the state who have indicated a desire to participate in this project.

Physician Assistant Development Program. This

is an expansion of the earlier Medical Specialty Assistants project, directed to continued funding of the medical specialty students while at the same time assisting in the further planning and development of the evolving physicians assistant programs at Emory University and the Medical College of Georgia.

CATEGORICAL DISEASES PROGRAM

Statewide Cancer Program. In addition to the area cancer facilities, this program includes:

Radiation Therapy Assistance. To improve treatment planning, physics support, and continuing education in radiation therapy through the development and implementation of a cooperative radiation therapy program among facilities in the region that provide radiation therapy.

Tumor Registry. The continuation of the support of the central part of the tumor registry which is a means of improving health care through improved follow-up of cancer patients and by providing a means of studying the results of treatment.

Facility Planning & Development. This project is to support initial planning and development for an area treatment facility for cancer in the Augusta area, which will be jointly utilized by all the hospitals in the area.

Community Hypertension Program. A continuation of the activity initially planned as a two-year effort and not funded until September, 1970. This project provides screening for hypertension and studies factors that deter indigent patients from medical care of hypertension, trying to discover methods to motivate their seeking and accepting care.

Educating Health Professionals in Optimal Diabetes Care. This project supports training opportunities for physicians and allied health personnel in the management of diabetic patients, through the Diabetes Day Care Center operated by the Diabetes Unit of Emory University in cooperation with Grady Hospital.

Regional Pediatric Respiratory Center. The continuation of GRMP support to help define needs, develop health care services, and expand training opportunities relating to obstructive respiratory diseases, at the Medical College of Georgia.

FACILITIES AND SERVICES PROGRAM

Emergency Care for South Georgia & North Florida. This project will provide the initial impetus for development of cooperative arrangements among groups of hospitals and physicians to improve emergency services with emphasis on capability for quick response to coronary attacks and highway accidents.

A Health Maintenance Program for Stephens County. To detect early disease or serious risk fac-

GRMP FIELD SERVICES

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Director of Field Services
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Albert Green
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tors for disease and encourage correction of these abnormalities, and to serve as an entry into the health care system for people who would not normally seek early medical care.

Training in Detection and Elimination of Electrical Hazards. A project to reduce the electrical hazards associated with the complex electrical equipment and power distribution systems in Georgia hospitals.

Statewide High Risk Maternal/Infant Services. To initiate development of a plan for a statewide system of health care of high risk mothers and infants with emphasis on reducing hazards of prematurity.

Patient and Family Education. To demonstrate improved methods of providing patient and family education, concentrating initial efforts in an area

facility hospital; and to share the results of these efforts, including teaching materials, throughout the state.

Optimism for the Future

GRMP embarks on its first year of the new triennium with several distinct notes of optimism:

- We are encouraged by the receipt of recognition from the Regional Medical Programs Service and the National Advisory Council that GRMP has the capability and the support needed to continue to develop and implement our own program in a way best suited to solving problems that Georgia providers of care have identified.

- We are pleased to have earned the opportunity to respond quickly and meaningfully to assist providers in their efforts to improve health care for the urban and rural poor through the use of a developmental component funding mechanism.

- We are hopeful that additional monies, already appropriated by Congress, will be released to the RMP by the Office of Management and Budget as the Administration becomes even more mindful of the meaningful relationships established between providers of health services and the individual RMP's.

- Finally, and perhaps most importantly, we are immensely appreciative of the continuing commitment to our goal and objectives that has been evidenced by providers of health services in Georgia. Without such commitment, we could have accomplished nothing in the past, and would hold little hope for the future. With such commitment and cooperation, we can continue to assist Georgia providers in the pursuit of our mutual objectives.

938 Peachtree St., N.E. 30309

HIGHLIGHTS OF GMCF, INC., BOARD OF DIRECTORS MEETING

Friday, September 17, 1971

Appointments: High-Pay Provider Review Project: L. C. Buchanan, and J. T. Christmas, Co-Chairmen. Committee on Nursing Home Criteria: J. D. Bateman, Albany; S. O. Poole, Gainesville; Don Schmidt, Cedar-town; Earl McGhee, Dalton; C. E. Bohler, Brooklet; J. S. Wilson, Atlanta; H. G. Davis, Jr., Sylvester; and O. G. Rawls, Albany.

Medicaid Project: Learned of the Board of Health decision that all nursing home admissions will be allowed for 14 days during which GMCF will evaluate the admission. Admission requests must be received in seven days with the remaining seven days for evaluation and return.

EMCRO: Learned that the GMCF Board will serve as the Advisory Committee to Experimental Medical Care Review Organization, the federally funded study project staffed by MAG studying the essentials of a Professional Standards Review Organization.

Minimum Standards: Deferred until the October meeting a request from the Georgia Psychiatric As-

sociation for re-evaluation of minimum standards for health insurance plans.

Communications Tape: Directed the Staff to present to the next meeting of the Board the slide tape program prepared by the AMA Field Service on GMCF and the San Joaquin Foundation movie for a determination of a GMCF orientation and promotion program.

Hospital Utilization Review: Voted to proceed with the development of a utilization review mechanism which might be used by all local Utilization Review Committees.

Relationships With Third Party Carriers: Staff was directed to invite representatives of Blue Cross-Blue Shield in the administration of the Federal Employees Health Insurance Plan and representatives of Prudential Medicare to the October meeting of the Board so that they might see the review process in operation.

Next Meeting: 2:00 p.m., Saturday, October 16, 1971, MAG Headquarters.

The Mass Casualty Plan: Some Basic Concepts

MAG COMMITTEE ON EMERGENCY MEDICAL SERVICES,* *Atlanta*

FOR ANY HOSPITAL, a mass casualty situation exists when the influx of patients exceeds the capacity of the hospital to manage the load in terms of personnel and/or supplies. In order to be prepared for such an eventuality, all hospitals should have a Disaster Plan; and all hospital personnel should be familiar with it. Indeed, a Disaster Plan is required for all hospitals accredited by the American Hospital Association.

The following material presents, in a capsuled form, some of the basic concepts useful in devising a Mass Casualty Plan for a hospital of virtually any size. No attempt has been made to be exhaustive; many sources of reference exist enabling expansion and added detail for each of the principles presented.

When

In general, and whenever possible, the Mass Casualty Plan should go into effect *before* existing facilities and personnel are overwhelmed by incoming casualties. Authority to place the Plan in effect should be delegated to the Disaster Committee Chairman and/or Hospital Administrator.

Who

One physician should be named to be in charge of and to act as Director of all emergency operations. Another should be named as Director of the Emergency Department. A Triage system should be set up early in the operation of the Plan. A mature, experienced physician must act as Triage Officer. He should be previously appointed as part of the Mass Casualty Plan, and this should be his only duty. If possible, he and one or more other physicians could be sent to the site of disaster to initiate the Triage system at that location as soon as possible.

The Hospital Administrator must act quickly to insure a flow of supplies and additional personnel at the times and places they are needed. Additionally, the Administrator should be responsible for the security of the hospital and casualty handling area. He should see that all hospital doors, except those needed in passing casualties and supplies, are locked. Police, or security personnel, should guard all en-

trances and exits and should direct and clear traffic in ambulance areas and nearby streets and parking areas when necessary.

What

To assure beds for incoming casualties, all patients in the hospital for diagnostic studies or elective surgery and those whose life and welfare would not be jeopardized should be discharged. The mechanism for such discharges and the person(s) responsible for discharging patients should be previously agreed upon and made a part of the Mass Casualty Plans for the hospital.

Communications between the hospital and the site of disaster should be established if at all possible. To accomplish this the hospital should have its own "high-band," dedicated radio system. If it has no such radio of its own, two police cars, civilian band (C.B.) units, or Walkie-Talkies can be used. This will help prevent an overload of other communication facilities with consequent delay in treatment of those seriously injured who might be cared for earlier by being diverted to another hospital. Communications with neighboring hospitals through telephone or radio is an early requirement to facilitate care in special cases such as neurosurgical, crushing chest injuries, burns, etc.

All visitors, families of the injured and the press should be barred from the casualty handling area by police! It is useful to send them to the blood collecting point.

Keeping of clerical records is the responsibility of the administrator. Clinical record-keeping is the responsibility of the physician. Nowhere is the medical record more necessary than in the mass casualty or disaster situation. It should be as complete and well-documented as possible. If the physician can bring his own secretary or office personnel to stand at his side, to run errands, etc., his record keeping job will be eased. At minimum, data in records must reflect identification of the patient, description of injuries including time, place and mode of occurrence, treatment and disposition.

It is suggested that food, such as sandwiches, milk and coffee be near the mass casualty handling area; available only to persons working in that area; and kept apart from that area.

*Requests for reprints should be addressed to: Committee on Emergency Medical Services, 938 Peachtree St., N.E., Atlanta, Georgia 30309.

If the magnitude of the disaster is such that physicians, nurses, and other critical personnel are required to perform in excess of 10 to 12 hours, do not use up these people in the first hours. The factors of fatigue and exhaustion should be considered. Arrangements for relief teams should be made by the Director with the advice of the nurse in charge and the Administrator.

In mass casualty situations involving civil disorder police should be assigned to hospital areas where disorder or destruction may occur. Police should be assigned to the casualty handling area and should escort treated ambulatory patients outside immediately upon completion of treatment. Police should be assigned to ward areas where victims and those who assaulted them may accidentally be assigned to adjoining beds. Preferably there should be separate ward areas for "prisoners" and "non-prisoners."

Miscellaneous

A Roster of available specialists, with phone numbers, should be available at all times. This should be prominently posted in the Emergency Department and the hospital telephone directory, and a copy should be kept by the telephone operator, Disaster Director, and Administrator. There should

be space reserved near the casualty-handling area for extra stretchers and wheel chairs which can be collected from other areas in the hospital. Physicians should be readily identifiable. It is suggested that a scrub suit, worn only by physicians, could serve this purpose or that the stethoscope be draped around the neck for identification.

Place the Coroner in charge of the morgue as early as possible, and keep the area guarded. Each body should be properly identified. Clothes and personal property should be placed in a plastic bag and tied to each body. Bodies should be released only by proper authority upon identification by a responsible member of the victim's family.

A Mass Casualty Plan should be tested at frequent intervals and reviewed by the Mass Casualty Committee of the hospital at least monthly. Further, the status of supplies stockpiled for the use in a disaster situation should be evaluated at frequent intervals and all drugs and sterile supplies kept fresh and current. The principles outlined in the foregoing, it is hoped, summarize the important basic concepts necessary for the evaluation or establishment of a Mass Casualty/Disaster Plan for virtually any hospital.

938 Peachtree St., N.E. 30309

CARPENTER NEW FIELD REPRESENTATIVE

Wallie R. Carpenter, a 28-year-old Mississippian, is MAG's new field representative.

Born in Grenada, Mississippi, he was graduated from the Mississippi Baptist Hospital School of X-Ray Technology in 1964, and from the University of Southern Mississippi at Hattiesburg in 1967.

Mr. Carpenter served as Assistant District Scout Executive in DeKalb County from 1967 to 1968, and has worked in medical sales and advertising in Jackson, Mississippi. He and his wife, Barbara, are presently residing at 2275 Gray Highway, Macon, Georgia.

In his new capacity as MAG Field Representative, Mr. Carpenter will cover the south Georgia area, calling on County Medical Society officers and individual physicians. He will also work closely with Allied Health Recruiting and Physician Placement.



The author discusses his experience with carotid endarterectomy in the treatment of patients with cerebral vascular insufficiency.

The Surgical Treatment of Carotid Artery Obstructions

MILTON F. BRYANT, M.D., *Atlanta**

ONE HAS TO BE somewhat frightened and shudder a bit in giving a talk to surgeons regarding his views on "How I Treat Strokes." My position reminds me of the recent World Champion Heavyweight Boxing Match. Prior to the fight, Cassius Clay was constantly telling the news media, "How I Do It." During the fight, Joe Frazier showed him how he did it and subsequently made a musical recording "I Did It My Way." I am sure that following my presentation—"How I Do It"—many of you will counterpunch me by telling me—"How You Do It." Of course, this is how it should be as there are still many controversial aspects to the surgical treatment of patients with cerebral vascular insufficiency.

The first successful carotid artery reconstructive procedure was performed in England in 1954 by Eastcott, Pickering and Rob.¹ Since that time, many successful carotid endarterectomies have been performed upon patients with cerebral vascular insufficiency.^{2, 3} Carotid endarterectomy is now well established in the surgeon's armamentarium. In 1960, this author⁴ discussed the surgical treatment of patients with cerebral vascular insufficiency before the Annual Meeting of the Medical Association of Georgia which was held in Columbus. Since that time, our indications for surgery have become somewhat more precise; however, we still have a number of unsolved problems.

Magnitude of Problem

The magnitude of the problem is indicated by the report of the Joint Study⁵ in which it was found that 74 per cent of ischemic stroke syndromes had at least one significant stenotic lesion in the extracranial vasculature. This report also brought attention to the fact that the intracranial vessels are frequently surprisingly free of disease and this is particularly true of the vessels after they have perforated the brain substance. These findings stress

the fact that many patients with the stroke syndrome can be benefitted by appropriate vascular surgery.

In analyzing our series of over 2,000 patients, we found that 62 per cent of the patients were males and 38 per cent were females. The average age for the male patient was 64.5 years and the average age for the female patient was 66.9 years. The youngest patient in the series was 32 years of age and the oldest patient was 92 years old.

Classifying Patients

Patients with cerebral vascular insufficiency may be classified into four major groups. The first group consists of patients with Transient Cerebral Ischemia. Under this classification two categories are recognized, the first category being patients who present with Focal Attacks of Neurological Dysfunction. These attacks may consist of ocular, speech, sensory or motor dysfunction. The attacks last from a few minutes to several hours and in order to qualify for this classification, the attack must clear up within a 24-hour period. The second category under Transient Cerebral Ischemia is Generalized Cerebral Ischemia. These attacks are characterized by episodes of fainting, severe dizziness and blackout spells. No localizing neurological deficits occur. The attacks last for varying periods of time; however, to qualify for this category, the attacks must not last more than 24 hours. Patients with Transient Ischemic Attacks frequently are candidates for surgery. They often have localized, segmental, stenotic or ulcerating lesions in the proximal portion of the internal carotid arteries. Carotid endarterectomy will usually relieve the disabling symptoms, prevent frank stroke formation and increase the long term survival rates for these individuals.

The second classification of cerebral vascular insufficiency is made up of patients who present with a Frank Stroke. This classification includes any patient who has a recent neurological deficit. All degrees of severity are seen; however, this classification does not include patients with old stable strokes.

* Presented at the 117th Annual Session of the Medical Association of Georgia, Atlanta, Georgia, May 13-16, 1971.

It does include patients with the RIND syndrome (reversible ischemic neurologic deficit) in which the neurological deficit lasts more than 24 hours and then clears. If the patient presents with a mild neurological deficit, and if after five days no infarcted area is seen on the brain scan, it is felt that one can proceed with arteriographic study and, when indicated, appropriate corrective arterial surgery. Patients who present with a profound stroke such as a flaccid hemiparalysis, aphasia and coma are not candidates for immediate arteriograms and surgery. These patients should be treated conservatively and usually after five to six days an infarcted area will be clearly demonstrated on the brain scan study. Early carotid endarterectomy in these patients may cause hemorrhage into the infarcted area with increase in the neurological deficit or possible death. After these patients have been observed for three weeks they should be re-evaluated for arteriographic study and possible vascular surgery. At the present time we feel that one should not operate upon patients who have an acute profound stroke, a rapidly progressing stroke or a rapidly improving stroke. It has been found wise to have the patient in a stable neurological state before proceeding with arteriograms or any type of surgery.

The third classification of patients with cerebral vascular insufficiency is patients with Chronic Cerebral Ischemia. These unfortunate individuals are usually brought to see the vascular surgeon by relatives pleading for help. The patients characteristically have a loss of memory, frequently they are not oriented as to time, place or person, and their mentation is severely impaired. Frequently motor deterioration accompanies loss of frontal lobe activity. In the past a number of these patients have been subjected to surgery by various surgeons and, in general, the results have been poor. Except in rare circumstances arteriograms and surgery are not recommended for these patients.

Finally, vascular surgeons are asked to see patients who have Asymptomatic Carotid Bruits. These bruits have been picked up on routine auscultation of the neck and the patients sent to a vascular surgeon for evaluation. Frequently, after taking a careful history, these patients are found *not* to be asymptomatic. They may be having transient cerebral ischemic symptoms which only come to light after careful probing. It has been noted by several authors that patients who have so-called asymptomatic carotid bruits will at some time in the near future develop symptoms of cerebral vascular insufficiency. These patients present a controversial and vexing problem; however, unless there is some contraindication, we feel that most of these patients should be studied with arteriograms. Arteriography as performed today is safe and can be recommended

fairly liberally. If the patient is found to have a stenotic lesion in the internal carotid artery that compromises the lumen more than 50 per cent one must consider corrective surgery. This is particularly true if the patient is going to have major surgery where hypotension may occur. In addition, patients of the younger age group (40-50) whose general status is excellent probably should have corrective surgery. Javid and his associates⁶ have shown by serial arteriographic studies that many of these atheromas will increase in size as much as 25 per cent in a one-year period. After careful evaluation and selection of these patients one can recommend surgery knowing that the mortality rate with carotid endarterectomy in these patients is less than one per cent.

Arteriographic Studies

There is still some disagreement about the type of arteriographic studies that should be performed in patients with cerebral vascular insufficiency. During the late 1950's two vessel studies were carried out visualizing both carotid systems along with one vertebral system. During recent years four vessel arch arteriograms have become popular and are performed in many institutions. This type of study can be helpful when indicated and we use it frequently. One must make certain that a simple arch aortogram is not performed as with this type of study one does not visualize adequately the intracranial circulation. Added catheterization of the carotid vessels must accompany an arch aortogram in order to visualize the intracranial vasculature adequately. With careful evaluation of the patient and correlation of the physical findings, two vessel carotid arteriograms with multiple intracranial views are adequate in many instances. Recently it has been shown that antibodies do not develop following intra-arterial injection of the various contrast media that are presently available. One must seriously question any report of an allergic or anaphylatic reaction to contrast material injected intra-arterially. I am not aware of any proven allergic reaction to contrast material injected intra-arterially. Problems that result from arteriography are usually related to technical errors and can be avoided by making certain that one does not commit a technical error. At the present time most carotid arteriograms are performed under general anesthesia or by injecting 10-15 mg. of Valium intravenously. Valium works well, avoids the necessity of general anesthesia and the expense of another team member. We use 50 per cent Hypaque or 60 per cent Renografin as the contrast media; however, when an aortic arch arteriogram is performed, 76 per cent Renografin or 80 per cent Angioconray provides better contrast.

It is important to obtain adequate intracranial views as well as two views of the vessels in the

cervical region. Several patients have been referred to us with a stroke-like syndrome and arteriograms revealed a typical subdural hematoma. Likewise, on occasion, a metastatic or primary neoplasm will be detected on arteriographic study. It is felt that at least three views—a Townes view, an oblique view, and a lateral view—should be obtained on each side in order to make certain that one does not overlook intracranial pathology masquerading as a stroke syndrome. If one obtains a complete history and performs a vascular and neurological examination, it is not felt that serial x-rays are necessary for the usual patient presenting with cerebral vascular insufficiency.

Significant Lesions

The debate continues regarding what constitutes a significant arteriographic lesion. As is the case with most diagnoses, all facts must be correlated and sound judgment used. In general, from a hemodynamic standpoint, it is felt that a 50 per cent reduction in luminal diameter must occur before there is a change in pressure or flow rate across a stenotic lesion. When associated stenotic lesions occur intracranially as well as extracranially, one again must use mature judgment in recommending or not recommending surgery. Actually, patients who have severe stenosis of the extracranial arteries associated with stenosis of the intracranial arteries may have a more urgent need for surgery than a patient who has isolated stenosis of the proximal portion of one internal carotid artery. We have measured the pressure gradient across many stenotic lesions in the internal carotid artery. When the luminal diameter has been decreased by 60 per cent there is always a marked pressure gradient across the stenotic lesion. Following carotid endarterectomy, the pressure is restored to normal. Flowmeter studies have also been carried out showing decrease in flow rates across lesions stenosing the artery 60 per cent or more and restoration of a normal flow rate following endarterectomy.

An atherosclerotic plaque may be significant even though it does not occlude the luminal diameter by 50 per cent. These lesions are ulcerative lesions and small thrombi form in the ulcerations. The thrombi become dislodged and cause distal cerebral embolization. At times cholesterol crystals may become dislodged and will be seen in the retinal arteries during a cerebral ischemic attack. We have seen Hollenhorst crystals in the retinal arteries on numerous occasions when the patient was having a cerebral ischemic attack; however, between attacks, the occurrence of Hollenhorst crystals in the retinal arteries is relatively rare. Actually, most transient

cerebral ischemic attacks are probably produced by ulcerating plaques rather than stenosing plaques. At times the ulcerations may be seen on routine arteriography; however, at other times, it is difficult to visualize the atheromatous ulcerations. Using the subtraction technique, one may visualize these ulcerations more frequently than one can when the vessel is filled with contrast media.

Protection of Brain

As far as protection of the brain during the operative procedure is concerned, we feel that general anesthesia with Halothane causes cerebral vasodilatation and can be given with 99 per cent oxygen. Hypothermia is no longer used and we do not feel that induced hypertension is necessary. We try to maintain the patient at a normotensive level; however, if hypotension does occur, we give an intravenous drip of NeoSynephrine. We have not had any experience using Diamox. It is felt that these patients should be kept in a normocarbic state and that hypercarbia and hypocarbia should not be used. In using hypercarbia and hypocarbia one is trying to shunt blood away from brain tissue that is richly supplied with blood to areas that have poor vascularity. In other words, one tries to produce the "Robin Hood" syndrome; however, in reality, tissue probe studies frequently reveal that instead of producing the "Robin Hood" syndrome, one ends up producing the "Sheriff of Nottingham" syndrome. One can use an intraluminal or extraluminal shunt; however, we prefer to use a polyvinyl intraluminal shunt. Heparin, 4000 units intravenously, is given prior to applying vascular clamps and at the end of the procedure, the Heparin is neutralized with 50 mg. of Protamine Sulphate. The carotid sinus nerve is always blocked with one per cent Procaine and if mobilization is necessary, we do not hesitate to section the carotid sinus nerve.

As far as internal shunts are concerned, we will grant that an internal shunt is not necessary in every case. Perhaps only one or two patients out of every 100 will require a shunt. We know of no test that will give precise knowledge as to which patient may need a shunt. Therefore, in order not to take any chances, we have elected to use an internal shunt routinely in every patient with a partially occluded carotid artery. Actually, when one becomes accustomed to working around a shunt, it is no more difficult to perform an endarterectomy with a shunt in place than it is to perform an endarterectomy without a shunt. The preferred shunt is made of polyvinyl and one can obtain these shunts in varying lengths and diameters. The shunt is removed just before placing the last few stitches in the arteriotomy incision. Internal shunts add very little to the operating time and add a great deal of security to

the surgeon and to the patient. It is a simple, reliable method of cerebral support while performing a carotid endarterectomy.

From a technical standpoint, one can make an oblique skin incision or a transverse incision. We prefer to make a vertical arteriotomy starting in the carotid bulb region and extending the incision beyond the distal end of the plaque. It is important to have the distal end of the plaque under direct vision so that it can be tailored or stitched into place in case a smooth breakoff does not occur. Dissection of the distal intima is a catastrophe that can and should be avoided. The arteriotomy incision is closed with # 5-0 or # 6-0 dacron or Tevdec arterial sutures. One should never use silk sutures as aneurysm formation may occur with loss of tensile strength. In general, if we cannot close the arteriotomy incision over a 4 mm. polyvinyl shunt with ease, we always insert a dacron patch graft. One should avoid stenosing the endarterectomized segment. We feel that liberal use of a dacron patch graft is warranted. We have numerous follow-up arteriograms showing these patch grafts in place and functioning well for periods up to 12 years.

Summary

A discussion of 15 years of experience with carotid endarterectomy for the treatment of patients

with cerebral vascular insufficiency has been presented. It is felt that by careful selection of patients, cerebral blood flow can be returned to normal in patients who have significant stenotic lesions and recurrent cerebral embolization can be prevented in patients who have atheromatous ulcerative lesions in the base of the internal carotid artery. Carotid endarterectomy can be carried out with an acceptable mortality and morbidity rate. In experienced hands, the mortality rate should be less than one per cent.

1938 Peachtree Road, N.W.

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ATLANTA EAR, NOSE AND THROAT SOCIETY FORMED

The Greater Atlanta Otolaryngology Society was formed August 26, 1971, to inspire study and research in otology, rhinology and laryngology. It will also serve as a clearing house or forum wherein such individual study and research may be presented and discussed for the advantage of the Society, and the profession generally.

The newly elected officers are William E. Silver, M.D., President; Roger Cook, M.D., President-Elect; J. A. Carter, M.D., Secretary and Ethan Staats, M.D., Treasurer.

Acute Abdominal Pain and a "Bump" on the Left Diaphragm

FRANK OWENS, M.D., WILLIAM SPENCER, M.D., and H. S. WEENS, M.D., Atlanta*

DR. FRANK OWENS: A 35-year-old colored male presented to the hospital with the chief complaint of acute onset of epigastric and left upper quadrant pain on sitting down following a day of work splitting rails and chopping wood. The initial films on this patient included PA and lateral chest films and recumbent and upright abdominal films. Dr. Spencer, would you comment on these?

Dr. William Spencer: The findings of possible significance on the chest film (Fig. 1) include a mass density in the left anterior cardiophrenic angle which cannot be separated from the left cardiac and left diaphragmatic margin. This mass is of homogeneous soft tissue density without evidence

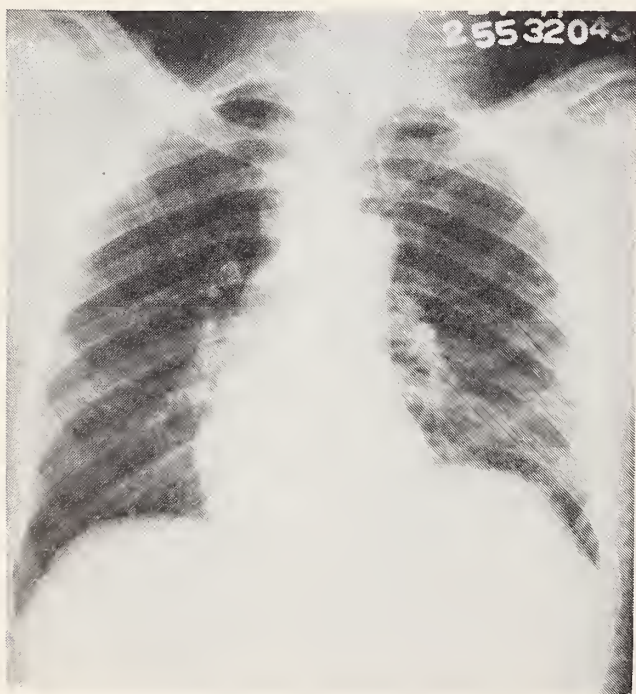


FIGURE 1—A & B

Chest films demonstrating a mass density in the left cardiophrenic angle producing a "bump" on the left hemidiaphragm.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements, Jr. and H. S. Weens.



FIGURE 1B

of gas within it. There is perhaps some slight shift of the heart to the contralateral side. There is an apparent increased thickness between the fundic air bubble and the superior margin of the diaphragm. There is also some blunting of the left lateral costophrenic angle. These findings suggest the possibility of a small left pleural effusion. A nasogastric tube is noted to be in place with the tip in the gastric fundus. Flat and upright abdominal films (Fig. 2) reveal no evidence of obstruction, with air seen in both the gastric fundus



FIGURE 2

Upright film showing air in the gastric fundus.

as well as moderate gas within the colon and some slight small bowel gas. Of possible significance is the presence of multiple healed pelvic fractures.

I do not feel that a definite radiographic diagnosis can be made from the films and history thus presented. The major radiographic findings boil down to the differential diagnosis of a mass density in the anterior cardiophrenic angle. This includes 1) lesions arising within the lung parenchyma such as bronchogenic carcinoma, 2) lesions arising in the visceral or parietal pleural membrane as in mesothelioma or within the pleural space such as a loculated empyema or 3) a mass density arising in the diaphragm. The latter includes the various mesenchymal tumors, the most common being lipoma, fibroma and myoma, as well as their malignant counterparts.

Final Consideration

The final consideration would be that the mass density arose beneath the diaphragm representing a diaphragmatic hernia. This might be a congenital diaphragmatic hernia; and in this case, a hernia passing through the foramen of Morgagni, a small triangular retrosternal space through which normally passes the mammary arteries. The Morgagni hernia is the most rare of the congenital diaphragmatic hernias making up less than 10 per cent. Strangulation of these Morgagni hernias rarely occur. Traumatic herniation is another possibility. Development of pleural fluid is an indication of strangulation of the hernia. This is explained by the fact that any pleural fluid originating from such things as irritation should have free access to the peritoneum with a defect in the diaphragm, except when this mode of exit is blocked by strangulation.

With the evidence of previous trauma, the history as presented, and the left anterior cardiophrenic mass density associated with small pleural effusion, I feel at this point the possibility of strangulated

traumatic diaphragmatic hernia is the most likely diagnosis. In view of the homogeneous density of this mass and absence of obstruction, it probably represents herniated omentum. Further studies such as pneumoperitoneum or G.I. series would be of value in further evaluation of this problem.

Dr. H. S. Weens: With a defect in the left diaphragm, what organs other than the omentum may herniate through?

Dr. Spencer: The colon herniates most commonly; however, there is no gas in the region of the mass above the diaphragm. The stomach, the spleen and the left kidney are also possibilities.

Dr. Owens: A gastrointestinal study was done on this patient which demonstrates the pathology (Fig. 3).

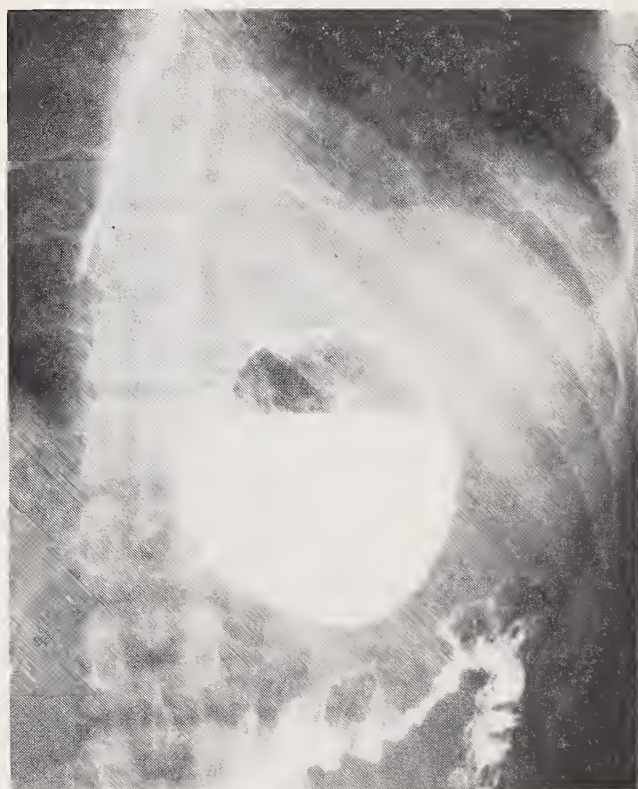


FIGURE 3

Upper gastrointestinal study after partial barium enema showing evidence of obstruction in the region of the body of the stomach. There is now evidence of left pleural effusion.

Dr. Spencer: The fundus of the stomach is outlined by barium and there is evidence of obstruction in the region of the body of the stomach. This would indicate that the mid and distal portions of the stomach have herniated through the diaphragm.

Dr. Owens: At surgery, there was found a defect in the diaphragm. The stomach showed organoaxial rotation with herniation of the body of the stomach through the diaphragm with strangulation. The antrum and duodenum were quite stretched secondary to this herniation (Fig. 4).



FIGURE 4

Photograph at surgery showing the junction of strangulated body of the stomach with the fundus.

Traumatic diaphragmatic hernias make up less than 5 per cent of all diaphragmatic hernias. Approximately 95 per cent of these occur on the left as the liver tends to protect the right. The central and posterior areas of the left diaphragm are most commonly involved. Blunt trauma is the initiating factor in approximately 50 per cent of the cases. The symptoms may not be evident for months, or even years, after traumatic incident. It is of interest that 90 per cent of all strangulated diaphragmatic hernias are traumatic in origin.¹

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

Saturday, September 18, 1971

Appointments: MAG Committee on Cancer—Herbert E. Brizel, Augusta; Charles M. Huguley, Jr., Atlanta, and Russell R. Moores, Augusta.

Georgia Educational Improvement Council Nursing Advisory Committee—John P. Wilson, Atlanta.

MAG Committee on Private Practice—Edwin E. Flournoy, Jr., Albany, and C. J. Walker, Jr., Gainesville.

Committees: Assigned responsibility for liaison with the AMA Committee on Health Care of the Poor to the Committee on Private Practice.

State Board of Health Recommendations: Voted to recommend to the Governor for appointment of one representing the Fourth Congressional District M. Freeman Simmons, Decatur; Leslie C. Buchanan, Decatur; and Earnest C. Atkins, Atlanta.

Medicare: Proposed that MAG spearhead changes in the Medicare law proposed by Dr. W. E. Mitchell, Jr., consultant to the Title XVIII, Part A Intermediary.

Georgia Medical Care Foundation: Noted an omission in the May, 1971 minutes of Council, stating that all changes in the GMCF Bylaws must be approved by Council.

Experimental Health Services Delivery Systems: Instructed Staff to proceed to develop the first draft of an MAG grant application to study the establishment of an Experimental Health Services Delivery System Health Care Corporation.

Field Service: Learned of the employment of Mr.

Wallie Carpenter, of Jackson, Mississippi, to service the South Georgia Field Service Region for MAG.

Drugs: Voted to recommend to Council that MAG make recommendations to the Governor for legislation on the prescribing of amphetamines.

Finance: Approved and recommended to Council a loan to the Medical Association of Atlanta operating capital in the amount of \$16,000.00 for 60 days at no interest.

Staff: Approved the employment of Mr. L. B. Storey as Assistant Director, Business and Finance, effective January 1.

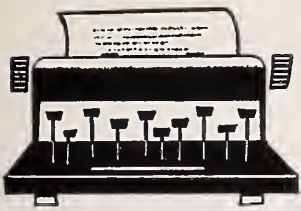
Approved the establishment of a consultant retainer for Miss Thelma Franklin beginning in April, 1972.

Composite State Board of Medical Examiners: Clarified the intent of the August, 1971, Executive Committee action appointing a four-man liaison committee so that the committee is available to discuss proposed changes in the Medical Practice Act, with the President or his designee to sit with the Board at its meetings.

AMA: Heard plans for the campaign of J. Frank Walker for AMA Speaker and approved the state-wide promotion of an AMA orientation by MAG Field Service.

Annual Session: Approved the granting of free exhibit space to the Bank of Georgia and the Security Life Insurance Company of Macon.

Next Meeting: 9:00 a.m., Sunday, October 17, MAG Conference Room, Atlanta.



Comments on Current Burn Therapy

ESCALATING HOSPITAL-CARE COSTS in all areas of patient management, particularly burns, has resulted in an increase in referrals of burn patients to centers, units, or individual physicians who are interested in the problem.

Major efforts toward reduction of morbidity and mortality will improve overall burn care and should include (1) early, adequate emergency care and (2) prevention or amelioration of the burn accident. Barring these two efforts, there is probably little that will influence or assist in improving the present situation.

Emergency Care

1. Brief, but effective, physical examination necessary to rule out associated injuries.

2. Immediate intravenous fluids, in generous amounts; e.g., 3 to 4 cc of Ringer's lactate per kilogram per per cent surface area burn per 24 hours. If the patient is to be transported to another facility, these should be specifically adapted for administration in transit.

3. Judicious, limited amounts of narcotics, sedatives, tranquilizers or relaxants, etc. (none if possible).

4. Antibiotics; tetanus prophylaxis.

5. Suitable treatment with topical chemotherapeutic agents with/without superimposed gauze dressings. Sterile sheets if the patient is being transferred elsewhere. Debridement, scrubbing, washing, etc. are not recommended.

Burn Prevention

Because there are splendid burn-care areas available to patients now, efforts might best be expended to instruct people in safety measures to avoid the burn accident, and, in addition, measures utilized to produce, prepare and encourage the wearing of non-flammable clothing.

Topical Wound Care

The search continues for more suitable topical therapeutic agents and this is certainly commendable. Even now there are a number on clinical research trial or under experimental study, but at present for clinical practice, only two are recommended and significant: (1) Sulfamylon® and (2) 0.5 per cent silver nitrate solution.

Other agents with promise have fallen into discard because of the rapid development of resistance of organisms (particularly *Pseudomonas*) when use has been continued and expanded.

Antibiotics

Resistance and mutation of organisms, as well as changing flora, in a burn wound continue to exist as a challenging problem to the development of new antibiotics. The increase of yeast in some types of topical treatment is also an intriguing clinical problem.

Certain burn accidents, particularly those caused by gasoline or electricity, and burns to the hand, are worthy of note because of peculiarities that arise in early therapy.

Gasoline Burns

Frequently burns due to gasoline (or other types of liquid fuel) are deceptively benign in appearance, as well as shallow in depth. The resultant burn is usually deep second or shallow third degree, but even these can result in marked supuration with puddling or purulent material under a moderately firm, dry eschar. Very early these patients can develop severe wound sepsis with marked febrile episodes and even septicemia. This may occur as early as the first five post-burn days. The offending organism (rarely streptococcus) is usually hemolytic *Staph. aureus* coagulase positive.

Electrical

Burns produced by electricity are unique due to the extreme heat, the unpredictable course of current through the body, and the variation of response of different tissue. An additional complication many times is the presence of associated injury. There is a very rapid loss of body fluids into the area of tissue damage in comparison to other types of thermal burns and is greatly out of proportion to the injury.

The rate of isotonic fluid administration intravenously should be more rapid and in larger volumes than in ordinary thermal burns, and as Baxter has noted, a satisfactory guideline is to establish urinary output at 50 cc or greater per hour and maintained for a few days after the burn.

Composition of the intravenous fluids should include bicarbonate or molar lactate to reduce acidosis.

In the electrical burn, fasciotomies are required more frequently than in thermal burns due to other etiologic agents.

Hand

Certain basic tenets are recommended: (1) Reduce edema, (2) maintain function (even immediately after burning), (3) avoid infection, (4) early skin coverage, (5) proper splinting and/or skeletal traction, (6) early escharotomy where the burn is circumferential around the hand or fingers.

Ultimate Goal in Rehabilitation

Despite all ancillary measures, the burn wound remains a basic surgical problem involving—(1) debridement, (2) grafting and (3) mobilization.

Pat C. Shea, Jr., M.D.

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WHAT DOES THE A.M.A. DO FOR YOU AND ME?

WHAT DOES THE AMA do for you and me? To answer this we will have to turn back the pages of history prior to 1847, before there was an AMA. At that time, medical education, as we know it today, was nonexistent. Diploma mills and inferior schools were turning out a continuous flow of incompetent practitioners and quacks. Medical degrees could be bought and there were those who claimed to be physicians who had never had any medical training. Quackery and traffic in patent medicines were widespread and the medicine man was challenging the doctor of medicine for the public's confidence and there was no recognized code of ethics, even among physicians.

The first medical school in this country opened its doors in 1765. By 1800, there were 10 medical schools, but the apprentice system was still more popular. In the early 1800's, fewer than 10 per cent of those practicing medicine had graduated from a medical school, and more than 80 per cent had never so much as attended a lecture in a medical school. Reputable physicians were concerned and were committed to improving the standard of medical education and the medical care of the people. They were also concerned with bringing together and consolidating the efforts of the widely scattered and already existing medical societies to produce a unifying force by organizing a permanent national organization.

It was with these thoughts in mind that in 1847, 250 physicians, dedicated to the cause of quality medical care, organized the American Medical Association. There were representatives from 40 medical societies and 28 medical schools, coming from 22 of the then existing 29 states. The meeting was held in the Academy of Natural Sciences in Philadelphia, with Dr. Nathan Smith Davis, of New York, who is given credit for founding the AMA, providing the leadership. Dr. Nathaniel Chapman was selected the first president and the basic objectives were "To promote the science and art of medicine and the betterment of public health." Now, 124 years later, these basic objectives remain constant.

Soon after its organization, the AMA urged the states to license physicians, "to make sure they meet certain qualifications"; to register births, marriages and deaths and that all packages or bottles containing poison be labeled "Poison" and on another label give the antidote; to set up individual state boards of health; that the United States establish a public health service and that every city and town have a sewer system and that hygiene be taught in public schools. An editorial in the *Journal* of the AMA in 1895 condemned the pollution of the Great Lakes and other rivers and bodies of water in this nation. The AMA has always tried to make this country a better place—a healthier place to live.

Around 1900, the AMA asked the Carnegie foundation to survey all medical schools. The report, published in 1910, shocked the nation and generated a public

outcry against inferior schools. They folded by the dozens and out of the chaos there remained 66 schools having joint approval of the AMA and the medical college association. One hundred other schools didn't qualify for membership. State licensing boards, which were now functioning, declared that they would only examine graduates applying for licenses from approved schools. Today's 103 medical schools are still accredited by the AMA and the medical college association. The AMA also accredits residency programs as well as continuing education courses for practicing physicians.

Today, with 970 employees in the headquarters staff, the AMA continues to diligently maintain its original objectives, "To promote the science and art of medicine and the betterment of public health." Eight hundred physicians give of their time without remuneration to serve on 16 councils, 56 committees and three commissions in an effort to further these causes.

The AMA publishes an information booklet on *The American Medical Association*—it's free—and it would be most helpful and informative if all our members obtained a copy and found out what the AMA does for you and me, and all the services that are available, just for the asking.

See you next month,

W. C. Mitchell

W. C. Mitchell, M.D.
President, Medical Association of Ga.

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THE CLINICAL RECOGNITION OF PERICARDIAL DISEASE

I. SYLVIA CRAWLEY, M.D., *Atlanta*

PERICARDIAL DISEASE may present as many problems. In order to properly resolve these problems the clinician must be able to recognize the chest pain, the variable physical manifestations, and the laboratory abnormalities that can occur with acute and chronic pericardial disease.

The correct diagnosis of chest pain due to pericarditis requires a high index of suspicion and the careful collection of historical data. Pericardial chest pain may be mis-diagnosed as angina pectoris or acute myocardial infarction. This may be quite costly for the patient since acute pericarditis is frequently a benign process, whereas the diagnosis of coronary disease implies a serious prognosis and may in turn result in serious psychological, social, and economic impairment of the patient. The use of anticoagulants and cardioactive drugs in patients with acute pericarditis is both unnecessary and hazardous. In both acute pericarditis (which may be recurrent) and ischemic heart disease, the diagnosis must often be made primarily on the basis of history since the physical examination, electrocardiogram, and chest x-ray may be normal. Most attention should be given data with the most specificity. Exertional chest pain radiating to the left arm and relieved with rest is more specific for ischemic heart disease. Chest pain aggravated by the supine position, deep breathing, swallowing and movement of the thoracic wall, relieved by sitting forward, and radiating to the interscapular area is more specific for pericarditis. Characteristic electrocardiographic changes in ST and T vectors may occur in pericarditis. The early ST segment abnormality is elevation in the antero-lateral leads (I, II, V4 and V6), accompanied later by T wave inversion in these leads. Loss of ECG voltage may develop with accumulation of pericardial fluid. The development of a pericardial friction rub tends to occur earlier in the course of acute pericarditis than in acute myocardial infarction. Fever, tachycardia, arrhythmias and leukocytosis may occur in both acute pericarditis and myocardial infarction.

Diagnostic Clues

Chronic constrictive pericarditis may present with hepatomegaly, ascites, and jaundice. Failure to properly examine neck veins may result in an incorrect diagnosis of cirrhosis. Elevation of deep jugular venous pressure with the characteristic "W" configuration pulse contour or a prominent Y trough will be appreciated. Additional clues include pericardial knock, quiet precordium, pericardial calcification, normal to increased heart size radiographically, and low voltage on the electrocardiogram. Pulsus paradoxus may be present but occurs less frequently than in acute tamponade. Peripheral edema may not be present.

Apparent cardiomegaly by x-ray may not be recognized as lax pericardial effusion, especially if the paucity of additional evidence for heart disease is not appreciated. Myocardial disease cannot be seriously considered in the absence of murmurs, gallop sounds, abnormal precordial pulsations and deep jugular venous pressure elevation. Diminished cardiac pulsations by fluoroscopy and decreased

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

electrocardiographic voltage may be helpful; however, both these findings may occur in diffuse myocardial disease. Right atrial angiography is the most definitive procedure for differential diagnosis and should be done prior to attempting pericardiocentesis. Recognition of pericardial effusion may aid in the recognition of underlying systemic disease, e.g., myxedema.

Cardiac tamponade must be recognized as a cause of shock. Tamponade may occur in the course of acute pericarditis from a variety of causes. Anticoagulant therapy in a patient with unrecognized pericarditis may initiate hemopericardium and tamponade. Chest trauma, cardiac surgery, and aortic dissection may be followed by tamponade. Marked elevation of deep jugular venous pulsations with a prominent X descent and obliteration of Y descent, pulsus paradoxus (inspiratory decrease in systolic blood pressure or diminished amplitude of peripheral pulse during quiet respirations), diminished precordial pulsations, and absence of gallop sounds are helpful observations.

The differentiation of biventricular myocardial disease with congestive heart failure from chronic constrictive pericarditis may be quite difficult. This differential diagnosis is important since the patient with constrictive pericarditis may respond to surgical correction and may deteriorate with aggressive diuretic therapy, whereas the opposite response can be expected in patients with myocardial disease. Cardiomegaly, neck vein distention, hepatomegaly, peripheral edema, pulsus paradoxus, low voltage on the electrocardiogram, and diminished cardiac pulsations on fluoroscopy may be present in both. Pericardial calcification, a quiet precordium and the absence of murmurs and gallops may be helpful clues to the presence of constrictive pericarditis. Cardiac catheterization is occasionally necessary to confirm the correct diagnosis.

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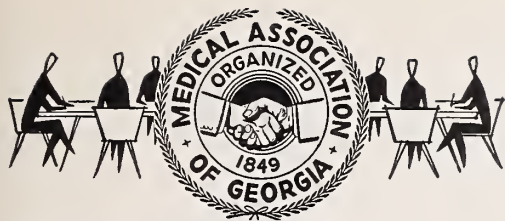
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SOCIETIES

The **Bibb County Medical Society** has contributed \$1,000 to the Middle Georgia Council on Drugs, for operation of the council program.

The **Medical Association of Atlanta** is beginning an educational program among its members, to urge them to voluntarily restrict prescriptions for amphetamine and metamphetamine drugs. It is asking that use of these drugs be limited to cases of narcolepsy, selected cases of hyperactive and brain damaged children and selected psychiatric conditions.

PERSONALS

Fourth District

H. Homer Allen of Decatur retired in September after 43 years in the practice of medicine.

Fifth District

James T. King of Atlanta presented a paper entitled, "Modified Exploratory Anterior Tympanotomy in Chronic Secretory Otitis Media in Children," at the Annual Session of the American Academy of Ophthalmology and Otolaryngology, held September 19-24 in Las Vegas, Nevada.

The Medical Diagnostic and Research Laboratory, P.A., under the direction of **John T. Godwin** of Atlanta, has been awarded a certificate of accreditation by the College of American Pathologists.

Sixth District

Lawrence L. Allen, Jr. and **Thomas A. Sappington**, of Thomaston, have been named charter diplomates of the American Board of Family Practice.

Ninth District

Wesley Wayne Harris of Royston has been named a charter diplomate of the American Board of Family Practice.

Tenth District

Walter Jones Revell of Louisville has been named a charter diplomate of the American Board of Family Practice.

DEATHS

Tom A. Dover

Tom A. Dover died September 7 at his home in Athens. He was 56.

Dr. Dover received his M.D. degree from Emory University and was in private practice in Athens until 1971, when he began practice in the emergency room of St. Mary's Hospital.

He was a member of the Crawford W. Long Medical Society, the Medical Association of Georgia, the American Medical Association and the Georgia State Obstetrics-Gynecology Society. He had served as president of the latter organization.

ASSOCIATION / Continued

Dr. Dover was a member and past chairman of the Clarke County Board of Health, member of the Athens Country Club and the Athens City Club, and Alpha Tau Omega social fraternity. He was also a member of Emmanuel Episcopal Church.

Survivors include his widow, Mrs. Virginia McDowell Dover; daughter, Mrs. Greer Rountree of Atlanta; two sons, Tom Allen Dover, Jr., of Jefferson and Jesse Carlton Dover, II, of Athens; grandson, Tom Allen Dover, III, and two sisters, Mrs. Claude Carter of Gainesville and Mrs. Bryon Turner of Bradenton, Florida.

William R. Edwards, Jr.

William R. Edwards, Jr., died September 1 from injuries received in an automobile accident in Atlanta. He was 40.

Dr. Edwards was graduated from Emory University and received his M.D. degree from Emory's School of Medicine. Following a surgical internship at Emory University and Grady Memorial Hospital, he was in general practice in Austell until 1962. He returned to Emory University for his otolaryngology residency, which he completed in 1966, at which time he joined the staff of the Ponce de Leon Infirmary.

He was past Vice President of Emory University

Alumni Association, served on the Peer Review Committee of the Medical Association of Georgia, was a member of Fulton County Medical Society, Medical Association of Georgia, Southern Medical Association, the Greater Atlanta Otolaryngological Society, the Georgia Society of Otolaryngology, and the Atlanta Clinical Society.

Dr. Edwards is survived by his widow, the former Alicia Mary Busser; two sons, William R. Edwards, III and Michael B. Edwards; one daughter, Marion Cecillia Edwards; a sister, Mrs. R. C. Richardson, and his mother, Mrs. Lucy Edwards.

J. H. Grubbs

J. H. Grubbs died September 20 at his residence in Molena. He was 87.

Dr. Grubbs was graduated from the Atlanta Medical College in 1913, and had practiced in Molena since that time. He was a member of the Medical Association of Georgia and the American Medical Association. He was a member of the original staff of the Upson County Hospital.

He had been a Mason for 53 years and was a member of the Molena Baptist Church.

Dr. Grubbs is survived by his widow; daughters, Mrs. Ben T. Jordan of Molena, and Mrs. Max P. Burgess of Tallapoosa; three sisters, six grandchildren and two great-grandchildren.



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HIGHLIGHTS OF COUNCIL

Saturday, September 18, 1971

Finance: Accepted the audit of fiscal year 1970-71 as presented by Treasurer, John S. Atwater, and Auditor, Mr. Wayne Drake.

Approved payment for the terminated feasibility study on the Headquarters Building amounting to \$1,-160.55 and appropriated \$350.00 for the Committee on Insurance and Economics mailing, \$1,500.00 contribution to the Southern Governors' Conference, and \$200.00 to finance a mailing for J. Frank Walker's campaign for AMA Speaker. Voted to instruct the Committee on Finance to include in its next budget proposal \$1.00 per dues paying member to the Medical Association of Georgia Foundation, to be held in a fund against future requests for assistance to destitute physicians and widows.

Governor's Reorganization: Heard a presentation by representatives of the Governor's office on state reorganization and authorized the Foundation and MAG to appoint representatives to meet within two weeks to discuss the matter further.

Foundation: Learned that only Council can amend the Bylaws of the Georgia Medical Care Foundation, Inc.

Legality of Physicians' Assistants and Status of Corporate Practice: Learned from Attorney John Moore that physicians' assistants are permissible under present Georgia law so long as they are not involved in final decision of diagnosis and treatment and they are under the supervision of a licensed M.D. (physical presence) and that under Georgia law, HMO's would be permissible on a per capita pay in, fee for service pay out basis.

Annual Session: Determined that Executive Committee and Council would meet on Wednesday pre-

ceding the 1972 Annual Session and declined a recommendation that Annual Session sites be selected by the Committee on Annual Sessions.

Component Societies: Adopted the Bylaws of the Medical Association of Atlanta and the Rabun County Medical Society subject to review by the MAG Committee on Constitution and Bylaws.

Certificate of Need: Voted to reconfirm Council's position opposing Certificate of Need legislation for health facilities.

GaMPAC: Learned that GaMPAC Bylaws were amended so that Council will appoint the GaMPAC Board of Directors, including the Executive Committee and members at large.

House of Delegates Actions: Voted to re-introduce to the House of Delegates language making membership available to Osteopathic physicians.

GRMP: Commended J. Gordon Barrow and the Regional Medical Program for their outstanding accomplishments.

Executive Committee: Heard an explanation from the Executive Committee clarifying the responsibilities of the Liaison Committee with the Composite State Board of Medical Examiners and referred back to Executive Committee consideration of a permanent appointment as MAG liaison representative to the Board.

Laboratory Licensure: Voted to support John T. Godwin's request that efforts be made to delete the section of the Laboratory Licensing Law requiring general licensure of small labs affiliated with a central laboratory.

Future Meetings: Adopted projected meeting dates through August, 1972, including December 11-12, 1971, Albany, and March 18-19, 1972, Callaway Gardens.

THE MONTH IN WASHINGTON

Health, Education and Welfare Secretary Elliot L. Richardson approved a proposed regulation to authorize insurance carriers to issue contracts for prepaid group medical service to persons in any state regardless of any restrictive state law.

Authority for the proposed regulation was granted by Congress last year in a law sponsored by Sen. Edward M. Kennedy (D.-Mass.) who also is the chief Congressional sponsor of organized labor's all-out national health insurance proposal. Under the terms of the law, the secretary of HEW can authorize insurance carriers who provide coverage through the Federal Employee Health Benefits program to issue contracts for the group medical services.

Forty-one prime health insurance carriers presently provide coverage through FEHBP. The actual number of insurance carriers affected by the law could total in the hundreds because of reinsurance contracts between prime carriers and other insurance providers, according to a spokesman for the department's Office of Group Practice Developments.

The regulation allows the HEW secretary to authorize the insurance companies "to issue in any state

contracts entitling any person as a beneficiary to receive comprehensive medical services from a group practice unit or organization" with which the company has contracted for the provision of group services.

Override Restrictions

The proposed regulation would be to override those restrictions, "enabling insurance carriers to issue contracts for prepaid group medical services to any individual in any state," an HEW announcement said.

HEW said as many as 50 million residents of the 20 states with laws restricting group practice could become eligible for group health plans.

Such plans, as described in the proposed rules, offer preventive, diagnostic and therapeutic medical services in a single organization on a prepaid basis.

"A medical group . . . shall include at least a general practitioner and representatives of each of the following medical specialties: general surgery, obstetrics, internal medicine, pediatrics and ear-nose-throat," the proposal said.

Kennedy applauded HEW's move but criticized the delay.

"The cause of the delay is no secret," he said in a statement. "For months the profitmaking commercial industry fought to obtain a larger role."
He said that while the intent of Congress prevailed the delay shows "the virtual stranglehold the health insurance lobby has on this administration."

Cancer Control

The American Medical Association told Congress that the attack on cancer can be most effectively conducted through the National Cancer Institute within the National Institutes of Health, rather than through a separate and autonomous agency.
Testifying before the House Health and Environment Subcommittee, Franz J. Ingelfinger, M.D., editor of the *New England Journal of Medicine* and a member of the Advisory Committee on Medical Sciences to the AMA's Board of Trustees, said that "the effort to cure cancer will have to be a coordinated effort with full involvement of all the national institutes (of health)."

"There is another compelling reason to retain the cancer program within NIH and that is to keep the NIH intact rather than have it become fragmented into independent agencies," Dr. Ingelfinger said. "Under the latter conditions the agencies would be competing for support and recognition rather than collaborating for scientific progress. The NIH is generally regarded in the international scientific community as one of the most splendid scientific achievements of the 20th century. To impair the effectiveness of this productive organization would be unwise. The integrity of the NIH should be maintained and increased support provided."

Dr. Ingelfinger expressed opposition to a compromise measure passed by the senate which would create a new independent Conquest of Cancer Agency within the NIH. He said that the autonomy proposed for such a new agency would "threaten the structure of the National Institutes of Health and impair research efforts in all fields."

Cautions Against Expectations

Dr. Ingelfinger cautioned against expecting any quick victory over cancer.
"We believe . . . that false hopes should not be created and that people should not be led to believe that with enough money and enough effort cancer will

quickly be conquered," Dr. Ingelfinger said. "Although many encouraging developments have occurred in the last few years that justify the major national effort proposed in House Bill 10681, the problems to be solved are very complex. Much basic research work remains to be done. Everyone should be prepared for steady but perhaps slow progress. We should also recognize that chance discoveries by scientists working in totally different fields may set the stage for significant future progress. This has occurred repeatedly in the history of scientific discovery, and consequently basic scientific research should be allowed a high degree of individuality and spontaneity."
". . . the American Medical Association advocates a program attacking cancer through greatly intensified and coordinated research efforts. We believe that in the interests of the public and in order to avoid any splintering of efforts, the program, adequately funded, should be administered within the National Institutes of Health under a Director having responsibility for all biomedical research."

Physician Shortage Areas

The AMA supported legislation that would provide federal aid to individual or small groups of physicians in establishing medical practices in rural areas, small towns and low income inner-city areas.
The legislation (S. 2269) would amend the National Housing Act to authorize mortgage insurance for the construction and rehabilitation of medical facilities for the practice of one to four physicians in physician-shortage areas. In 1966, mortgage insurance was authorized for establishment of non-profit group practices. The current legislation would extend that program.
Dr. John M. Chenault, a member of the AMA Board of Trustees, spoke for the Association. He said. "One of the problems in our health delivery today relates to a shortage of necessary manpower, as well as the lack of proper distribution. The shortage is particularly emphasized in rural areas and areas of low income. The failure of such areas to attract physicians can be attributed to many factors—tangible and intangible—and the problem is a complex one. We should, however, provide incentives and encouragement to physicians to meet the needs of those areas."

AMA Support

"The American Medical Association supports a pluralistic system of delivery of health care embrac-

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Feb. 11 9:00 a.m.-5:30 p.m.
Feb. 12 9:00 a.m.-3:45 p.m.

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\$15.00 Interns in Residence
PAYMENT OF FEES: May pre-register by paying fee in full
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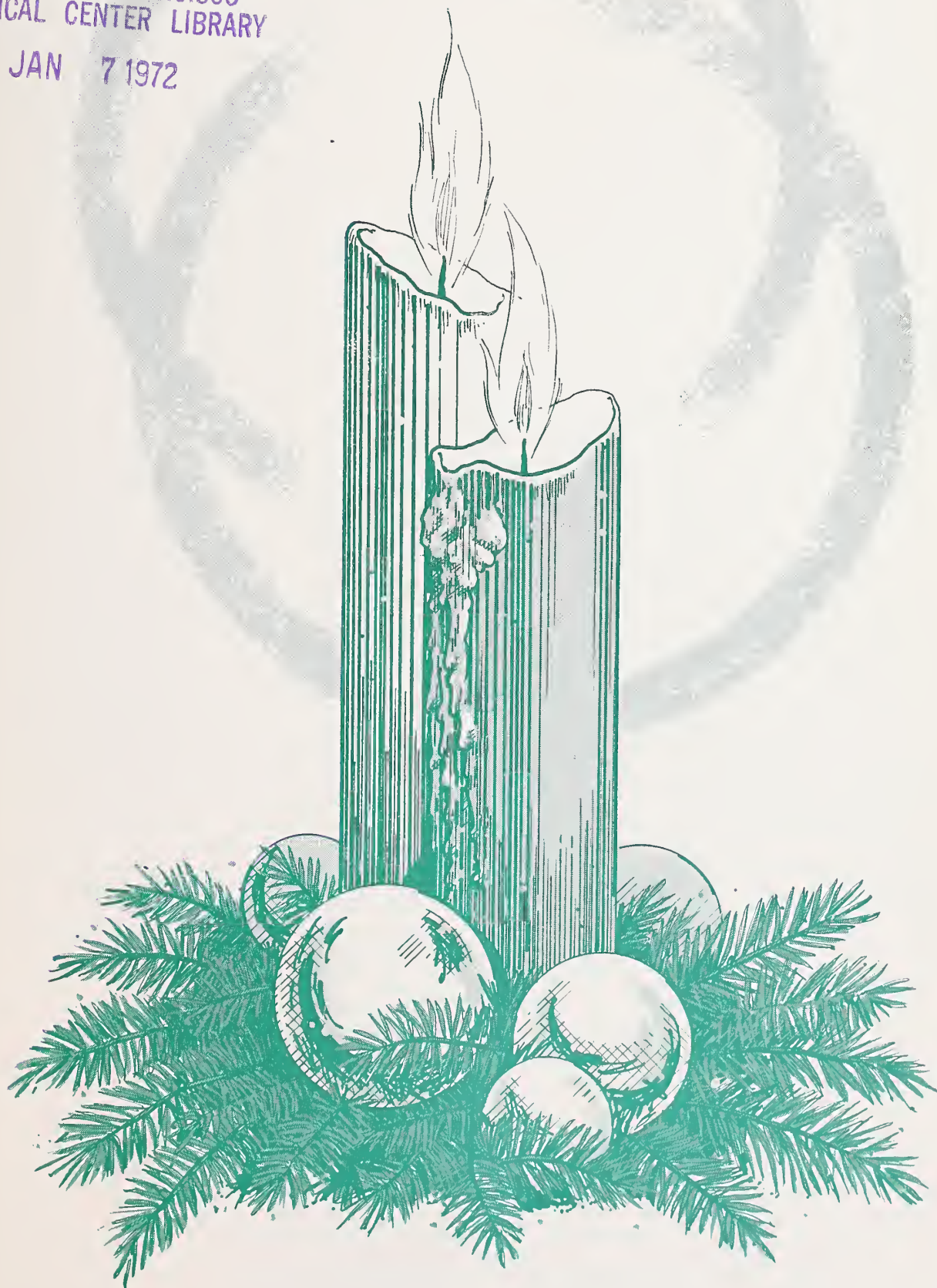
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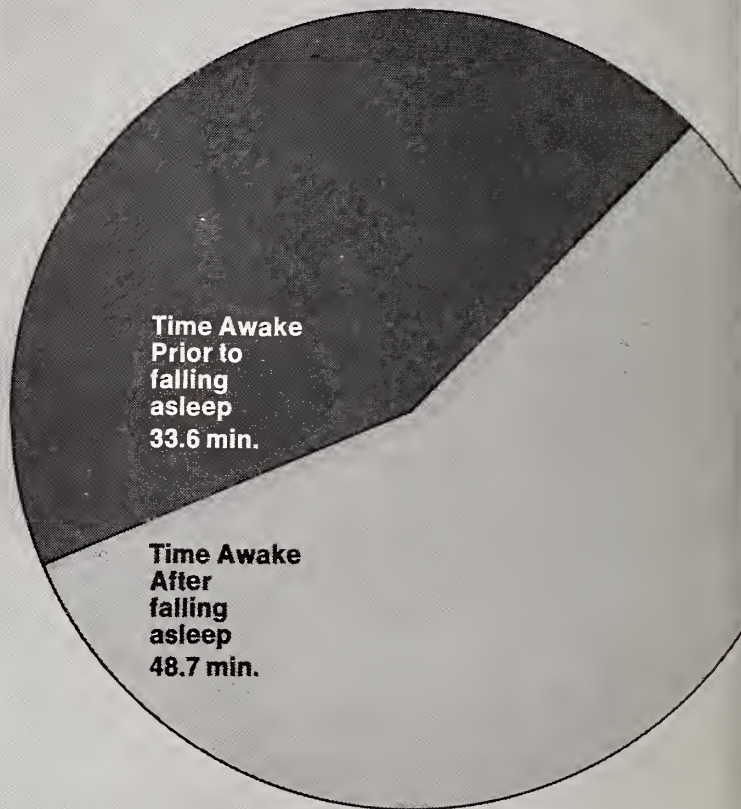
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References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.

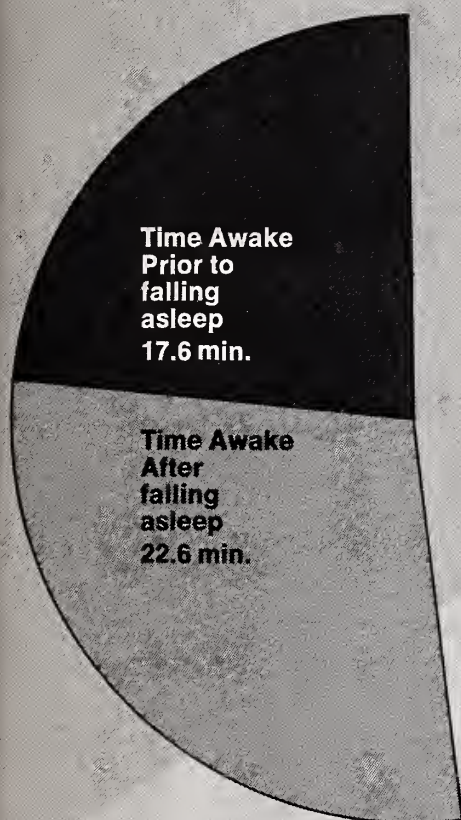
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

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Following an adequate history and physical examination, if one suspects the possibility of a neurosurgical lesion, these procedures can be used with a wide margin of safety.

A Ten-Year Experience and Analysis of Pneumoencephalograms and Cerebral Arteriograms in a Community Hospital

LOUIS A. HAZOURI, M.D.,* *Columbus*

IN MANY COMMUNITY HOSPITALS the neurosurgeon finds himself in a position of sharing the responsibility of overall care with the referring physician for a protracted period of time. In these capacities, neuroradiological contrast procedures such as angiograms and pneumoencephalograms are utilized frequently not only to determine the presence and location of disorders that require surgical treatment, but also to evaluate organic and functional neurological disorders. It is essential that each neurosurgeon working under these conditions continually reassess the diagnostic benefits of these procedures against the morbidity and mortality effect on the patient as well as the economic effect on the overall cost of medical care.

The purpose of this paper is to report the experiences in a community hospital in Georgia with a referral area including southwestern Georgia as well as southeastern Alabama with a radius of some forty (40) miles north and east in these respective states. These patients were all personally evaluated having been, with no exception, referred by other physicians for a neurosurgical evaluation and outline of treatment. This included the service patients as well. With the exception of the head injured, most had been seen and treated by their physician for an average of two weeks or more.

The data consists of the following: There were 6,400 pneumoencephalograms, 14,100 arterial punctures, (this latter figure including bilateral as well as unilateral studies) on a total number of 7,032 patients during the 10 year period between 1960 through 1970. This included 900 femoral catheterizations as well as 16 brachial angiograms.

Accumulated Information

The records were analyzed and the following information was accumulated.

Initially, pneumoencephalography and arteriography were performed as separate procedures. Unilateral arterial studies were the commonplace. The change in this approach has been insidious over the last seven years, and now four vessel selective arteriography, via femoral arterial puncture, is complementing and supplementing bilateral carotid arteriography. Percutaneous vertebral artery punctures are no longer done. Only four open brachial angiograms were performed. No open carotid angiograms were performed.

The patients examined were from a broad spectrum of clinical problems, the youngest being three months and the oldest 87 years of age.

Various contrast media has been previously used, Meglumine Diatrizoate-60 is used at present. Sodium Thiopental, Halothane, Diapezem, and now Ketamine Hydrochlorides are used either separately or in combinations. The latter in combination with intravenous Diapezem has proven most satisfactory. Only on a rare occasion has an endotracheal tube been necessary.

A thin walled 20 gauge or 22 gauge needle was used for all punctures except for femoral arterial catheterization. An 18 gauge short lumbar puncture needle is used for the latter.

Irrigations, anticoagulants and other ancillary devices were not used.

Manual injection for carotid arteriography is used. Four vessel studies were accomplished by a calibrated pre-set pressure injector with an automated radiograph changer.

* Presented at the 117th annual session, Medical Association of Georgia, May 13-16, 1971, Atlanta, Georgia.

Diagnoses

The clinical impression of surgical disease was confirmed in 197 brain tumors and 221 vascular lesions including aneurysms, an overall percentage of 2.8 and 3.1 respectively.

There were 1,621 craniocerebral injuries, both surgical and nonsurgical, for a percentage of 23. The percentage of positive studies in craniocerebral injuries were deliberately omitted for presentation at a later date.

Radiographic findings of vascular occlusive disease confirming or supporting the diagnosis of cerebrovascular disease were found in 1,385 records of a total of 2,220 patients, a percentage of 62.3 with an overall percentage of 31.5 of the total admissions.

Three hundred sixty-five patients were considered to have a neurological organic disorder, but had no neuroradiological supporting findings. These patients were not considered as cerebrovascular occlusive disorder suspects. This group formed 5 per cent of the total admissions.

There were 2,408 patients whose signs and symptoms suggested organic disease, but were most likely functional—a total of 34 per cent. Subsequent follow up of the clinical course has shown no evidence of progressive disease with the exception of four patients who proved later to have an infiltrative lesion.

The average hospital stay for patients who proved to be functional in origin was five days, including the date of admission and dismissal. This is not an unreasonable period of time when compared to the other general admission patients whose problems are potentially of less serious consequence.

Complications

Initially the complications were as follows:

1. Headaches, sore throat and dysphagia were nearly a common complaint of varying degree, but were short lived after 36 hours. Inguinal and neuritic discomfort was more conspicuous by its near absence after femoral puncture. The opposite held true in brachial and vertebral puncture, these patients complaining of burning pain for days due to peripheral nerve irritation.

2. Hematoma after an arterial puncture occurred in all cases by the very nature of the procedure; however, none were of any consequence as to require tracheostomy or surgical intervention.

3. There was no contrast media reaction, even in patients allegedly allergic to Iodine derivatives. This included those patients who had given a his-

tory of reaction during intravenous pyelographic studies.

4. There was no clinical evidence of vascular thromboses.

5. Venous "vasculitis" from Diapezem injection occurred in 146 patients.

6. Tracheostomy was performed on one patient who had a preexisting tracheal ring stenosis to complement therapy in an unusual case of intracranial hypertension secondary to chronic pulmonary disease.

7. There were no deaths.

8. There were no recorded neurological deficits.

9. Focal seizures occurred in seven cases, all of which were immediately controlled with supplementary doses of Thiopental Sodium with no residual deficit. This occurred in patients who were being studied for convulsive disorders.

10. There were no infections.

Comments

It is acknowledged that the diagnostic tools available in this technologically oriented time of our lives cannot be used indiscriminately, but if there is any clinical suggestion of an organic neurosurgical lesion existing, then the burden of proof must lay upon the neurosurgeon to prove or disprove this suspicion. The overlooked subdural hematoma in a "mental" patient or a multi-burr holed patient, the occult tumor in a "chronic vascular headache" female, the epileptic of years' duration with a vascular malformation are but a few of the examples which bring this point into sharp focus.

It would seem reasonable to conclude from the above analysis the following:

With an adequate history and physical examination, when one suspects the possibility of a neurosurgical lesion, that small air pneumoencephalography and cerebral angiography can be used with a wide margin of safety.

That these procedures in conjunction with electroencephalography and radioisotope scanning offer the patient a superb method of examination.

That the high number of functional neurological disorders evaluated emphasizes the need of a more strict set of criteria for hospital admission, notwithstanding that this latter group presents the dilemma of an acutely ill or chronic complaining patient with an anxious family and frustrated referring physician seeking consultation and the reassurance of not overlooking an organic disorder.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

Sunday, November 14, 1971

Membership: Directed that the County Society Officers Conference include a speaker on MAG membership and its benefits. Voted to send a letter to non-members encouraging them to seek membership if qualified.

Travel: Voted to allow the use of MAG's mailing list for folders promoting Medical Association of Atlanta's Orient trip. Voted to refer to the Committee on Group Travel the matter of organizing a Spring and Fall trip for MAG members.

Headquarters Building: Voted to allow the Building Expansion Committee to proceed with consideration of expansion of MAG Headquarters including the Feasibility Study.

Experimental Health Services Delivery System: Accepted MAG staff recommendation that a grant application for development of Experimental Health Services Delivery Systems be abandoned.

Peer Review: Voted to reassume responsibility for policy on peer review within the Executive Committee, leaving with the Committee on Peer Review responsibility for handling appeals.

Appointments: Heard from C. E. Bohler, M.D., that he will accept the appointment as liaison member to the Composite Board of Medical Examiners. Appointed Richard C. Parsons, M.D., to the Committee on Peer Review, as recommended by the Georgia Society of Otolaryngology.

Abortion: Agreed to receive a report from the Committee on Maternal and Infant Welfare and recommend to Council that MAG's position on abortion legislation be modified to support a limitation on the length of gestation to 20 weeks.

Committees: Appointed a Committee on Long Range

Planning, composed of F. William Dowda, M.D., Braswell Collins, M.D., David Wells, M.D., and F. G. Eldridge, M.D. This Committee, staffed by Mr. Moffett, will initially concern itself with the effects of proposed State Reapportionment.

Medicare: Voted to forward to the AMA Board of Trustees a copy of the resolution endorsed by Executive Committee recommending changes in Medicare Part A.

Osteopaths: Endorsed a joint MAG-Georgia Hospital Association legal opinion regarding Osteopaths on hospital staffs in an effort to assist Georgia hospitals in avoiding legal action through the improper wording of Staff Bylaws.

Foundation: Endorsed recommendations of the Georgia Medical Care Foundation that claims to consultants no longer be anonymized, so long as Legal Counsel approves; extended MAG employee benefits to Foundation employees; and endorsed the efforts of the Foundation to obtain closer liaison with specialty societies.

Department of Health: Voted to refer a Department of Health request for MAG authorization to eliminate smallpox vaccination in Georgia to the Georgia Board of Health.

Reorganization: Recognizing that administrative economies may be possible at the local level, voted to endorse the current structure of the Board of Health with the non-separation of the Department of Mental Health as MAG's official stand.

Blue Shield: Voted to advise Georgia's Blue Shield Plans that effective peer review can only be accomplished by organized medicine through its Foundation.

Next Meeting: During AMA Clinical meeting, New Orleans, and 10:00 a.m., December 11, Albany Down-towner.

Abdominal Mass With Non-Functioning Kidney

ELISE NEELD, M.D., ANTONIO GONZALEZ, M.D., *Atlanta**

DR. ELISE NEELD: This is a 55-year-old white male admitted with a two months' history of diarrhea. He had been on antibiotics for an abscess of the right hand and it was believed that the diarrhea was secondary to antibiotic treatment. On the week prior to admission, the patient had cramping pain in the left lower quadrant of the abdomen. He was seen in the clinic and a mass was palpated in the left upper quadrant of the abdomen. Dr. Gonzalez, would you look at the x-rays?

Dr. Antonio Gonzalez: The first film is a KUB. In this film, the most notable abnormality is a large left upper quadrant mass. A double density is seen, and is suggestive of an enlarged kidney associated with another mass. The lowermost portion of this



FIGURE 1

Upper gastrointestinal study showing a large left abdominal mass displacing the stomach superiorly, the jejunal loops inferiorly and the ligament of Treitz medially.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements, Jr. and H. S. Weens.



FIGURE 2

I.V. urogram 20 minute film showing normal right upper urinary tract structures and non-visualization of the left upper urinary tract.

mass superimposes the iliac crest. There is a definite impression that this is a retroperitoneal mass. The etiology of this mass is unclear. There are no other significant associated abnormalities on this film. Do you have other films?

Dr. Elise Neeld: This is a film from an upper gastrointestinal study (Figure 1).

Dr. Antonio Gonzalez: In this film, there is evidence that the large mass displaces the stomach superiorly, the duodenum and ligament of Treitz to the right and the jejunal loops inferiorly. Displacement of the ligament of Treitz suggests a retroperitoneal mass of large size located in the left abdomen. The possibility of a renal neoplasm is of first consideration. Other possibilities are a large renal cyst or hydronephrotic kidney. Any soft tissue mass adjacent to the left kidney, such as lymphoma, fibrosarcoma or adrenal neoplasm should

be considered. However, the absence of calcification and non-displacement of the kidney is of significance. I would think an I.V. urogram is in order (Figure 2).

Dr. Elise Neeld: This is a representative film from the intravenous urogram.

There is non-functioning on the left side up to five hours. The differential diagnosis, therefore, is that of a non-functioning kidney on the left side. In a mass of this size, three things come to mind: (1) Hydronephrosis; (2) Benign cyst; (3) Carcinoma. It is unusual, however, to have non-functioning in the case of a kidney with either a benign cyst or renal cell carcinoma.

Dr. H. S. Weens: What else would you consider in the differential diagnosis in that mass?

Dr. Gonzalez: With such a large mass, I am really hard put to think of other things. I would imagine an infiltrative process will give you a bilateral abnormality. I do not think infection is a good clinical or radiographic possibility; such a large accumulation of pus would be expected to produce a more toxic patient. Also, one would see some function on the I.V. urogram. Thus, I would again consider the three diagnostic possibilities I stated earlier to be the most likely diagnosis of the case at hand.

Dr. Wade Shuford: What next would you obtain?

Dr. Gonzalez: A retrograde pyelogram. A retrograde study was done, and there is considerable displacement of the left ureter to the right (Figure



FIGURE 3

Left retrograde uretero-pyelogram demonstrating massive hydronephrosis secondary to obstruction at the uretero-pelvic junction which is displaced to the right of the midline.



FIGURE 4

Surgical specimen showing massive hydronephrosis.

3). There is also a suggestion of stenosis of the proximal ureter at the uretero-pelvic junction. However, I do not see any contrast medium within the pelvis itself.

Dr. Weens: Look again.

Dr. Gonzalez: Well, one can see a double density which probably represents a hydronephrotic dilated sacculation. Again, the most likely possibility is that this is a hydronephrotic kidney.

Dr. Weens: Would you obtain further studies?

Dr. Gonzalez: I believe the diagnosis is established and I would not go any further.

Dr. Frank Underwood: We performed a renal angiogram to define the arterial supply for the surgeon.

Dr. Neeld: The left kidney was removed (Figure 4). There was massive hydronephrosis with complete destruction of the functioning renal substance.

Comment

In this case, the I.V. urogram should have been the initial examination of choice. With large palpable abdominal masses, there is frequent primary or secondary distortion of the upper urinary collecting systems. This is particularly true in infants and children.

Emory University 30322

This paper should help the practicing physician in understanding the V.A. hospital treatment program and thus facilitate post-hospital care of these tuberculous patients.

Tuberculosis Without Strict Isolation

ROSE ANN WEAVER, M.D.,* *Atlanta*

DURING THE PAST SEVERAL YEARS, many tuberculosis hospitals have closed. Subsequently, patients with pulmonary tuberculosis are being treated in general hospitals. The purpose of this report is to describe the policies of an open tuberculosis ward in a general hospital and secondly, to report the length of time required for sputum conversion in a group of patients on this ward.

Policies of the Ward

In September 1969 the Atlanta Veterans Administration Hospital opened an "open tuberculosis" ward. This is one of the first general hospitals to have such a ward. The policies for this ward were established in accordance with recent reports concerning infectivity of patients with pulmonary tuberculosis on anti-tuberculosis drugs,¹⁻⁵ and closely follows the guidelines for general hospitals concerning the admission and care of tuberculosis patients recently reported.⁶

The newly diagnosed cases of pulmonary tuberculosis are restricted to their rooms for the first two weeks of therapy and to the ward for the second two weeks. After four weeks of therapy the patients are allowed to go about the hospital at will (excluding other patients' floors). This includes the canteen area, recreation area, occupational therapy department, physical therapy department, audiology department and radiology department. It is the attending physicians' opinion that after one month of anti-tuberculosis therapy, the infectious potential is negligible in the majority of patients; therefore, it is an acceptable policy to permit the patients to leave the ward. Adjustments in the restriction policies are made for patients who require longer or shorter restriction periods. For example, patients with known resistant organisms may require longer restriction whereas a patient transferred from an-

other hospital on drug therapy may require shorter restriction.

Discharge policies for the ward are in accordance with the recent statements by the American Thoracic Society.⁵

Patient Treatment

During the two week-four week restriction period, intensive education of the patient by the medical personnel is conducted. The pathogenesis and transmission of pulmonary tuberculosis are taught. This includes the importance of the patient covering his cough, sneeze and laughter.

Sputum for AFB smear and culture is collected at weekly intervals on all the patients on the tuberculosis ward. Chest x-rays are routinely taken once a month. Laboratory data, including transaminase, hematocrit, blood urea nitrogen and creatinine are collected at monthly intervals. Patients on streptomycin have an audiology examination bimonthly and patients on ethambutol have a base line visual acuity examination and a follow-up examination at the time of discharge from the hospital.

The treatment of these patients usually consists of three drugs; although occasionally an alternating regimen utilizing four drugs is used. The average hospital stay is approximately five months. The reason for such a lengthy hospitalization period is multifactorial. The majority of patients have many social problems which include alcoholism, low income and minimal education. Prolonged hospitalization with intensive, close contact with the social work services is necessary in these cases in order to ensure good post hospital care.

No caps, gowns, gloves or masks are used on the ward. The cafeteria trays and dishes are handled in the same manner as they are on other medical floors. The tuberculosis ward differs from other medical floors in that the air in the heat and air condition units is not recirculated. These are the routine policies. Any additional data or policy required for an individual patient is ordered as indicated.

* Chief, Infectious Disease Section, Atlanta Veterans Administration Hospital, Instructor of Medicine (Pulmonary), Emory University School of Medicine.

TABLE I

I. Atypical disease cases	7
II. Resistant organism cases	6
III. Insufficient data	32
a. Short hospitalization* and questionable diagnosis	11
b. Transfer cases from AVAH to another hospital	4
c. AWOL or AMA cases	3
d. Positive bacteriology at the time this report was written†	6
e. Deaths soon after admission	4
f. Cases transferred from Army Hospitals to AVAH with negative bacteriology	4
IV. Chart cannot be located	1
Total number excluded	46

* This group includes a group of patients who received early discharge from the hospital. Complete bacteriological data was not obtained. These included reliable patients with minimal numbers of organisms in their sputum at the time of discharge. Also this group includes several patients admitted to the tuberculosis ward with "suspected tuberculosis" (diagnosis was not proven).

† At the time this report is being written, these six patients have only recently been admitted to the tuberculosis ward and have been on drugs for a very short period.

Results of Sputum Testing

The data presented will be on those patients admitted to the Atlanta Veterans Administration Hospital Tuberculosis Ward for the 14 months period from October 1, 1969 through November 30, 1970 and who adequately met the following criteria:

1. All patients must have *Mycobacterium tuberculosis* isolated from their sputum.
2. The *Mycobacterium tuberculosis* organism must be sensitive to the primary anti-tuberculosis drugs.
3. The patients must be newly diagnosed cases, thus receiving therapy for the first time.
4. The patients must be hospitalized for a sufficient

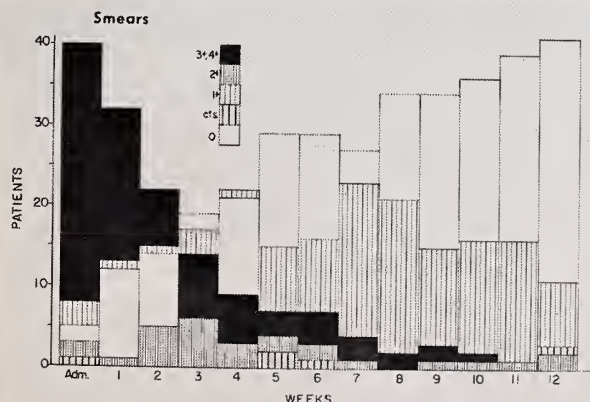


FIGURE 1

Drug therapy was begun on the day of admission. Note the rapid decline in heavily positive sputum, the majority of patients having negative sputum or only small number of organisms present after four weeks of therapy.



FIGURE 2

Note the rapid decline in heavy growth of the tuberculosis organism isolated from patients' sputum once drug therapy was begun. The majority of cultures were negative or revealed only small numbers of colonies after four weeks of therapy.

period of time to reach a negative bacteriologic status.

A total of 103 patients was admitted during the above designated period. Of these, 57 patients met the criteria as outlined. The 46 remaining patients did not meet the criteria and were not included (see Table I).

Of the total 57 patients used, 44 had far advanced disease and 38 of these were cavitary. Thirteen patients had moderate advanced disease and 5 of these had small cavities. None had minimal disease. The classification of disease was made in accordance with the 1969 publication of the National Tuberculosis and Respiratory Disease Association.⁷ All 57 patients received drugs to which their organisms were susceptible.

From concentrated early AM sputum specimens, smears and cultures were made and the number of AFB were evaluated. The smears were reported as numerous (3+, 4+) when one or more bacilli were seen in most oil immersion fields. They were reported few (2+) when 10 or more bacilli were seen per slide and rare (1+) when 3-9 bacilli were seen per slide. If less than 3 were seen, the actual count was reported. The cultures were reported in a similar fashion as follows:

- 4+ Confluent growth
- 3+ Heavy growth, not quite confluent
- 2+ Many discrete colonies, more than 200
- 1+ 20 to 200 colonies

The actual colony count was reported if less than 20 colonies were present.

Most of the patients had heavily positive sputum smears and cultures for AFB on admission. After two weeks of drug therapy the number of AFB seen on smears and cultures was notably decreased and after four weeks of therapy, a rather marked decrease in the number of AFB was noted (30 per

cent negative by smear and 20 per cent negative by culture) (see Figures 1, 2 and 3).

All patients were negative by culture at 7½ months. (Excluding one patient, all were negative by culture at 5¼ months.) One patient remained smear positive although his cultures became negative. As would be expected, the patients with far advanced disease required a longer period of time to become bacteriologically negative as compared to those with moderately advanced disease (Figure 4).

Remarks

The policies concerning patient restriction for the patients on the tuberculosis ward at our hospital seem to be acceptable ones; however, long term follow-up data is needed before this program can completely be evaluated. Data from long term follow-up of our tuberculosis cases, including the number of treatment failures, will be compiled as the information becomes available. Based on recent data in the literature on infectiousness of tuberculosis patients on drug therapy, these seem to be good standard policies to use. However, one should realize that deviations from the standard should be considered in individual cases. Restrictions could be less than stated in the policy for a patient who is not coughing and whose sputum contains small numbers of AFB. Whereas, a patient who continues to cough and/or has large numbers of organisms may need extended restrictions.

This report agrees with the report by J. Jones, et al. concerning sputum conversion and infectivity levels of patients with pulmonary tuberculosis on drug therapy. She has reported that there is a rapid decrease in the number of AFB present in the sputum of patients being treated with drugs to which their organisms are susceptible. Furthermore, she

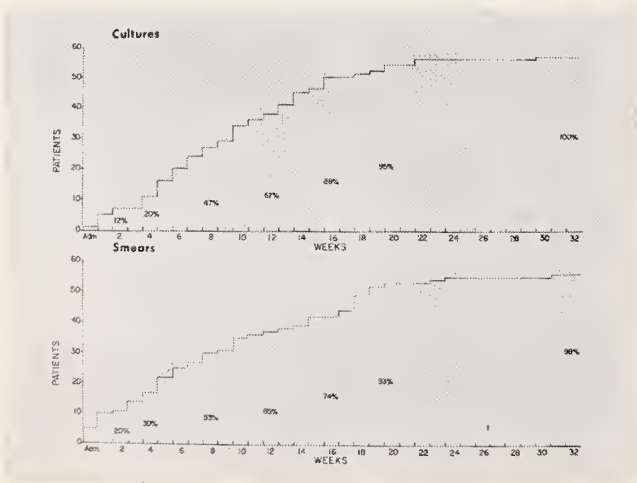


FIGURE 3

Actual number and percentage of patients with sputum negative bacteriology after drug therapy was begun.

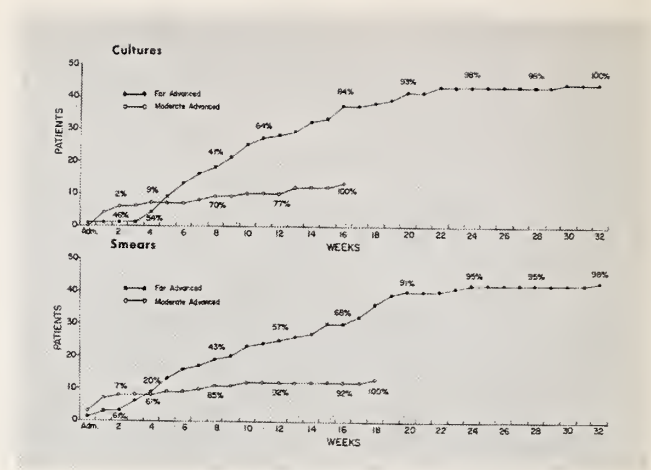


FIGURE 4

Those patients with far advanced disease required a longer period of time to reach negative bacteriological status when compared with those patients with moderate advanced disease.

states this decrease usually begins within the first two weeks and continues rapidly with complete disappearance of the organisms within 30 days in one-third of the patients studied.¹

Other factors affecting infectivity levels, such as decrease in coughing after beginning drug therapy, were also noted in these patients, although not documented by actual numbers of cough per day. R. London, et al. have reported that cough frequency during treatment with anti-tuberculosis drugs is rapid, most patients reducing their cough count to half the initial value within two weeks.² This lends further support to our “two week-four week” restriction policy.

As our outpatient clinic program gains support, shorter hospitalization periods are anticipated. Hopefully, the average hospital stay will be one to two months instead of the present lengthy stay of five months.

The medical personnel on the tuberculosis ward are being skin tested every four months and perhaps the results of this study will be reported at a later date.

The advantages of the “two week-four week” policy are probably more appreciated by the patient than the medical personnel. However, the practice of such policy in no way compromises the safety of the medical personnel. With all the new anti-tuberculosis drugs available and the present views concerning the infectiousness of tuberculosis, the patients who develop this disease need no longer dread prolonged, strict isolation policies as were practiced prior to the time of anti-tuberculosis drugs.

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Health Education in Schools

On health education in schools, the House resolved to encourage state and local medical societies "to establish active liaison with their school systems in order to provide lectures and appropriate educational support regarding: personal hygiene, the effects of tobacco and drugs, the problem of medical quackery and the role of physicians in maintaining good health."

CALL FOR SCIENTIFIC EXHIBITS*

118TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Macon, Georgia, May 11-14, 1972

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee

938 Peachtree Street, N.E. • Atlanta, Georgia 30309

* Space is limited at the Macon Hilton and requests for applications should be made early to establish priority.

The purpose of this paper is to describe for the year 1970 both the population entering the system, its mechanics, and outcomes for the population at Grady Memorial Hospital in Atlanta, Georgia.

Statistical Analysis of Applicants and of the Induced Abortion Workup

Grady Memorial Hospital—January–December, 1970

LAWRENCE D. BAKER, M.D.^{1*} and MALCOLM G. FREEMAN, M.D.,² Atlanta

THE CURRENT GEORGIA ABORTION LAW is a combination of legislative and judicial decisions. The law passed by the General Assembly of Georgia in April 1968 was patterned after the American Law Institute's Model Penal Code, Section 230.3. It stated that a woman must have at least one of three reasons—risk to life or health, rape, or probability of fetal deformity—to be considered for an abortion. On July 30, 1970, a Georgia Federal District Court ruled that specific indications were unconstitutional. However, the original procedural apparatus still remains. Three licensed physicians—a proposer and two consultants—plus two out of three members of a hospital committee must agree that an abortion is necessary for each individual woman. The requirements of the law became the framework of a system which processes the application of every woman desiring a legal abortion in Georgia.

Hospital Description

Grady Memorial Hospital is a 1,100 bed facility serving the medically indigent population of DeKalb and Fulton counties, Georgia. Included in this area is the major portion of Metropolitan Atlanta. Over 6,000 live births per year occur on the Obstetric Service. The number of induced abortions performed at Grady Memorial Hospital has increased each year for the past several years. In 1968, the hospital's physicians performed six induced abortions in 1969, 31; in 1970, 134. Extrapolating from the number of abortions performed per year, approxi-

mately 635 induced abortions will be performed in 1971.

"System" Description

The "system" or abortion workup consists of the following steps:

I. Contact with the abortion coordinator. The patient's initial and only continuous contact with the Grady abortion system is through the abortion coordinator, who counsels and explains the technical aspects of the abortion procedure, provides information on sterilization and post abortal contraception, schedules appointments for the medical examination and for interviews with the consultants, and arranges admitting dates for the patients approved by the Therapeutic Abortion Committee. In accordance with hospital regulations, the coordinator must obtain the consent of the husband, if he can be located, for a married woman. To comply with state law, she must arrange for a parent or guardian to consent for women less than 21 years of age.

II. Determination of geographic and financial eligibility by the Grady Investigation Office. The law requires that the woman be a bona fide resident of the state and the hospital requires that a patient be medically indigent and a resident of either DeKalb or Fulton county. Patients declared ineligible are referred elsewhere by the coordinator.

III. Medical examination. The examination must be performed by a licensed physician. For the woman to continue in the process, the physician must concur with the woman's reasons for the abortion and be willing to perform it. The law states that physicians believing that an induced abortion is morally or ethically objectionable are not required to participate in such procedures. Although there is no specific gestational restriction in the Georgia law,

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* The Family Planning Evaluation Activity, Epidemiology Program, Center for Disease Control, is funded in part through the Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Maryland 20014.

the policy of the Obstetrics Service is that pregnant women with gestational ages beyond 20 weeks are not considered for an abortion.

IV. Interview with the two consultants. Except when candidates have major medical complications, both consultants are usually psychiatrists. They must certify that abortion is necessary before the case can be presented to the abortion committee.

V. Presentation to the Therapeutic Abortion Committee. The committee's decision is based upon the woman's gestational age and the written opinion of the consultants. Two of the three members must vote affirmatively that the abortion is necessary. Patients not approved by the committee are referred

by the coordinator for prenatal care or to other physicians or facilities offering abortion services.

Characteristics of Abortion Applicants

In this report, an abortion applicant is any woman who communicates with the abortion coordinator for the purpose of obtaining an induced abortion at Grady Memorial Hospital. To characterize these applicants, the applicant ratio (number of applicants per 1,000 live births) is used. The applicant ratio is an improved though still incomplete estimate of the actual demand for abortion services. Table 1 shows that relative to women who give birth to live born infants at Grady, women who are most

TABLE 1
APPLICANT RATIOS BY AGE, RACE, MARITAL STATUS, NUMBER OF LIVING CHILDREN
AND EDUCATION
GRADY MEMORIAL HOSPITAL, JANUARY-DECEMBER 1970

	Women Giving Birth	Abortion Applicants	Applicants/ 1,000 Live Births
Age			
≤14	138	21	152
15-19	2,390	96	40
20-24	2,015	111	55
25-29	816	58	71
30-34	422	35	83
35-39	205	14	68
≥40	55	5	91
Unknown	1	1	—
Total	6,042	341	56
Race			
White	1,164	133	114
Black	4,869	199	41
Unknown	9	9	—
Total	6,042	341	56
Marital Status			
Currently married	2,960	71	24
Currently unmarried	3,056	261	85
Formerly married*	805	100	124
Never married	2,251	161	72
Unknown	26	9	346
Total	6,042	341	56
Living Children			
0	2,603	89	34
1	1,412	74	52
2	773	55	71
3	479	32	67
4	303	23	76
5	174	11	63
6	297	11	37
Unknown	1	46	—
Total	6,042	341	56
Education—Last Grade Completed			
≤6	70	3	43
7-9	881	48	55
10-11	1,165	84	72
12	974	105	108
≥13	158	48	304
Unknown	2,794	53	19
Total	6,042	341	56

*Separated, widowed, and divorced women constitute formerly married women.

TABLE 2		
GRADY MEMORIAL HOSPITAL THERAPEUTIC ABORTION APPLICANTS BY REASON FOR NOT COMPLETING THE PROCESS—1970		
Reason for Withdrawal	No.	Per Cent
Committee disapproval	43	21.8
Grady ineligible	35	17.8
Changed mind	33	16.8
Not pregnant	20	10.1
Gestational limits	20	10.1
Spontaneous abortion	12	6.1
Minor unable or unwilling to obtain consent	9	4.6
*Rejection of system by patient ..	2	1.0
Other	10	5.1
Unknown	13	6.6
Total	197	100.0

*Although rejection of system signifies that the candidate changed her mind, we have considered it a separate category. Change of mind implies the candidate decided to continue with pregnancy because she felt abortion was not the proper choice. Rejection of system implies, rather, that it was the workup or process itself that chiefly brought about the change of mind.

likely to apply are very young, white, formerly married, and better educated.

Outcome of the 341 Applications

Of the 341 applicants initially applying, 139 were ineligible or withdrew before they could be presented to the Therapeutic Abortion Committee. Among the 202 remaining candidates, 43 were not approved by the committee. An additional 15 applicants withdrew after a favorable committee decision. Thus, of the 341 applicants, 197 (57.8 per cent) did not obtain an induced abortion at the hospital. Their reasons are shown in Table 2.

Overall, 43 (21.4 per cent) of the applications presented to the Therapeutic Abortion Committee were not approved. Analysis by race reveals that of 84 whites, 67 (79.8 per cent) were approved. Of the 118 blacks, 92 (77.9 per cent) were approved. There is no apparent evidence of racial discrimination. However, examination of approval rates by marital status shows a statistically significant disparity ($p < .0005$). Of the 108 currently and formerly married women, 88 per cent were approved. In comparison, only 67.8 per cent of the 93 never married women were approved.

While these rates have not been altered by the Federal Court decision of July 30, 1970, official indications for induced abortions at Grady Memorial Hospital have changed (Table 3). Prior to the court decision, all applications approved by the Therapeutic Abortion Committee were approved for one of the traditional American Law Institute indications. After the court decision, the patient and the committee were no longer restricted to specific reasons. Accordingly, in August-December 1970, 32.9 per cent of the 106 applications approved were requesting abortion for such reasons as socio-economic problems, age, contraceptive failure, multiparity, narcotic addiction, marital crisis, and mental retardation. Yet, despite the committee's acceptance of non-American Law Institute indications for abortion, they nonetheless felt that 59 candidates or 55.7 per cent of the total had sufficient mental health indications to serve as primary justification for an induced abortion.

Abortion Workup Time

The median time required for an abortion workup is 15 days. Analysis by age, race, marital status,

TABLE 3						
OFFICIAL INDICATIONS OF INDUCED ABORTION APPLICANTS APPROVED BY THERAPEUTIC ABORTION COMMITTEE						
GRADY MEMORIAL HOSPITAL—1970						
Indications	January-July		August-December*		Total	
	No.	Per Cent	No.	Per Cent	No.	Per Cent
Maternal mental health	42	79.2	59	55.7	101	63.5
Rape	6	11.3	6	5.7	12	7.5
Maternal physical health	5	9.4	6	5.7	11	6.9
Socioeconomic	0	0.0	15	14.1	15	9.4
Age	0	0.0	10	9.4	10	6.3
Contraceptive failure	0	0.0	4	3.8	4	2.5
Multiparity	0	0.0	2	1.9	2	1.3
Narcotics addiction	0	0.0	2	1.9	2	1.3
Marital crisis	0	0.0	1	.9	1	.6
Mental retardation	0	0.0	1	.9	1	.6
Total	53	100.0	106	100.0	159	100.0

* Four cases voted on 1/71 (applied 12/70).

TABLE 4
NUMBER OF DAYS IN ABORTION PROCESS BY MENSTRUAL GESTATION AT APPLICATION,
CANDIDATES PRESENTED TO COMMITTEE
GRADY MEMORIAL HOSPITAL, JANUARY-DECEMBER 1970

Number of Days in Process	Menstrual Gestation at Application (Wks.)											Total
	0-4	5	6	7	8	9	10	11	12	13		
0-7	0	1	1	0	1	0	3	1	3	7		17
8-14	1	0	7	5	8	12	10	6	9	19		77
15-21	1	0	6	5	6	3	7	4	2	15		49
22-28	0	1	4	3	5	5	2	2	5	9		36
29-35	0	1	1	2	0	0	0	2	1	3		10
36-42	0	1	0	1	0	0	2	0	2	0		6
> 42	0	0	1	1	1	0	0	2	1	1		7
Total	2	4	20	17	21	20	24	17	23	54		202

number of living children, and education does not show any differences in the time spent in processing any one group. Table 4 shows the number of days spent in workup for those candidates presented to the Therapeutic Abortion Committee by menstrual gestation at application. At application, 26.7 per cent of the candidates had a menstrual gestation of 13 weeks or greater. Another 29.2 per cent of the candidates (enclosed within the heavy margins of Table 4) had gestational ages of less than 13 weeks at application, but by the time of committee decision these candidates had gestational ages of 13 weeks or more. Thus, at the end of the workup a total of 55.9 per cent of the applicants presented to the Therapeutic Abortion Committee were in the second trimester of pregnancy.

Applicants Not Obtaining Abortion

Table 5 analyzes the pregnancy outcome of the 197 candidates who did not obtain an abortion at Grady Hospital by the reason for not completing

the process. Applicants who were Grady ineligible obtained abortions elsewhere at the rate of 48.6 per cent while eligible candidates not approved by the committee obtained abortions elsewhere at the rate of 41.9 per cent. The woman's marital status appears related to the outcome of pregnancy for those whose applications were not approved by the Therapeutic Abortion Committee. Of the 30 never married, 56.7 per cent obtained an abortion elsewhere, whereas only 8 per cent of the 13 formerly and currently married obtained abortions elsewhere. This relationship to marital status does not apply to women dropped from the process because of Grady ineligibility.

Applicants who withdrew or were dropped for other reasons (that is, gestational limits, change of mind, minors and "other" reasons) usually decided to continue with the pregnancy, although a few had spontaneous abortions or were later found not to be pregnant. Of the two patients who rejected the idea of the workup per se, one decided to continue with

TABLE 5
PREGNANCY OUTCOME OF ABORTION APPLICANTS NOT HAVING AN ABORTION AT GRADY
MEMORIAL HOSPITAL BY REASON FOR NOT COMPLETING THE PROCESS
JANUARY-DECEMBER 1970
Reason for Not Completing the Process

Pregnancy Outcome	Grady Ineligible	Gestation Limits	Changed Mind	Committee Disapproval	Minor	Rejection	Other	Unknown	Not Pregnant	Spontaneous Abortion	Total
Birth or still pregnant	6	18	23	16	3	1	2	4	0	0	73
Legal abortion elsewhere	13	0	0	13	0	0	3	0	0	0	29
Spontaneous abortion	2	0	7	5	1	0	0	0	1*	12	28
Not pregnant	1	0	1	0	1	0	0	0	19	0	22
Illegal abortion	4	0	0	5	0	1	0	0	0	0	10
Other	0	0	0	0	0	0	3	0	0	0	3
Unknown	9	2	2	4	3	0	3	9	0	0	32
Total	35	20	33	43	8	2	11	13	20	12	197

* Patient withdrew because she was told she was not pregnant. She later aborted spontaneously.

the pregnancy and the other obtained an illegal abortion. We did not have any recorded suicides or other maternal deaths.

Abortion candidates who withdrew from the process and had an abortion elsewhere usually utilized resources outside of the Georgia medical care system. Of the 39 patients who obtained induced abortions, only 13 (33.3 per cent) had a legal abortion performed by a physician licensed in the State of Georgia. Of the remaining 26 (66.7 per cent), 16 had a legal abortion, most often in New York; the other 10 had an illegal abortion, usually in Atlanta.

Discussion

Although the applicant ratio provides an indication of patient interest in abortion services in the Grady population, the ratio does not reflect the actual induced abortion ratio. For 1970, while there were 56 applicants per 1,000 live births, the number of induced abortions performed at Grady was only 22 per 1,000 live births.

While the white applicant ratio is 2.8 times greater than the black applicant ratio, it must not be assumed that blacks in the Fulton and DeKalb county areas are uninterested in induced abortion services. Experience from Alaska, California, Delaware, and Maryland shows that black ratios can be similar or even greater than white abortion ratios.^{1, 2, 3} It is certainly possible, therefore, that continued dissemination of information concerning the availability of legal abortions at Grady Hospital may soon lead to significant increases in black applicants.

Group Identification

The identification of groups of women who frequently apply for abortions is important because it describes a population of women in need of contraceptive services. The Hospital Abortion Surveillance conducted by the Center for Disease Control suggests that the majority of legally induced abortion patients were not using contraception at the time of conception. In order to decrease the occurrence of induced abortion, the providers of contraceptive services should consider some or all of those groups with high applicant ratios as prime target populations.

For 54.3 per cent of the abortion candidates, the mechanics of the Grady abortion system forced their discontinuation in the abortion process. However, the system may have helped the 16.8 per cent who voluntarily withdrew to decide that an induced abortion was not the best solution for their pregnancy.

The existence of women who change their minds during evaluation implies the presence of ambivalent feelings among abortion applicants. Confused or undecided women may require aid as they consider the various alternatives to their pregnancy. While abortions may be the best solution for some women with unplanned pregnancies, for others it may be a mistake. Hopefully, pre-abortion counseling will avoid decisions that are later regretted. Another type of counseling appears necessary for women with actual mental health indications for abortion. In addition to the emotional strain caused by the unwanted pregnancy, these women usually have primary psychosocial problems. For this group, emotional support, psychotherapy, and social services may be necessary before, during, and/or after the abortion. The presence of ambivalent women and women with true psychiatric disease speaks for the importance of including both counseling and social services as integral parts of an abortion service.

The analysis of the decisions of the Therapeutic Abortion Committee shows that applications from never married women are approved significantly less often than applications from both currently and formerly married women. When the never married woman is turned down by the Committee, she obtains an induced abortion elsewhere 56.7 per cent of the time versus 8 per cent of the time for those ever married.

Although the applicant ratio more closely approximates the demand for abortion services than the abortion ratio, it is still a rough estimate. Obtaining an abortion is a complex selection process not only involving state laws, hospital policies, and professional attitudes, but also the prospective patient's knowledge of the existence of abortion services, her cultural milieu, and social skills and contacts. Community surveys will be necessary to gather information about the actual demand for abortion and to identify the factors that determine the number of patients who apply.

ADDENDUM—Since the preparation of this paper, the Department of Gynecology and Obstetrics has organized a Voluntary Interruption of Pregnancy Service at the hospital. Physicians on the Service perform both induced abortions and voluntary sterilizations. A report describing the program will be prepared.

69 Butler Street, S.E. 30303

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A New Birth Certificate Is Born*

AS WE APPROACH the final quarter of the twentieth century—"the age of the computer"—it has been said that data proliferates, but knowledge lags behind.

An imbalance frequently exists in the scientific area between the mechanical act of recording a fact and in progressing to infinitely more complex second stage: bringing to bear human judgment to draw a conclusion based at least in part on what that fact reveals.

Several Georgia health agencies—deeply concerned over badly matched "in-put" and "outcome" of health statistics—have combined skills to establish a system to acquire truly "vital" birth data. The system which a number of people working together evolved offers that captured data in readily available form to those professionals having valid call on it.

The end result of several years of consultation and study, a new "certificate of live birth" form, is now ready for use in Georgia; it is a document that for the first time contains a "confidential medical and health information" section. This means that as of January 1, 1972, a physician completing a birth certificate form will be preparing the initial in-put for a computerized data collection and retrieval system that will in time lead to significant changes in the provision of private and public health care in the state.

Form Development

The project which led to the final version of the soon-to-be-initiated form began in late 1970. State health director Dr. John Venable at that time responded to a Medical Association of Georgia request by assigning the Office of Operations Research of the State Health Department the task of exploring the possibility of collecting confidential medical data on a revised birth certificate form.

It was quickly determined that Georgia was one of the few states in the nation not already receiving information on congenital malformations or birth injury through the birth registration mechanism.

Basing their initial efforts on the National Standard

Birth Certificate form of the National Center for Health Statistics, the study team brought in advisers to validate their efforts to produce a form specifically useful in Georgia.

Assisting and advising as the study progressed were Dr. Eugene Griffin and Dr. Malcolm G. Freeman of the M.A.G. Maternal and Infant Welfare Committee; Dr. William Flynt, chief of the congenital malformations unit at the National Center for Disease Control; and health program directors within the Georgia Department of Public Health whose work touches the project. Included were directors of state programs of child health, crippled children's care, cardiovascular disease and mental retardation. Dr. Albert Schoenbucher, who is director of the state agency's maternal health program—and also serves on the Maternal and Infant Welfare Committee of M.A.G.—brought coordination between the views of both agencies.

New Certificate

The certificate, which will go into effect on January 1, has been given legal clearance and has also been structured in a way to ease data processing techniques.

It consists of three separate sheets, with only the first sheet containing the classified medical and health information section. As the form itself states, "This information is not a part of the legal record of birth and will not be reproduced on certified copies."

The form's second sheet is the "local copy" retained by the local registrar, and the third sheet—which contains health information for parents, as well as the basic birth data—is mailed to the infant's mother some two months following the child's birth.

New Year's Day in Georgia, 1972, then will see the initiation of a new vital record in the state, and the traditionally heralded "first baby of the year" will have his birth recorded on the new document. Members of Georgia's medical community can claim definite pride of authorship in the creation of the new certificate. Interest by physicians in maternal, neo-natal and infant mortality during the past two

* Prepared by Cavanaugh Murphy, Public Information Officer, Georgia Department of Public Health.

BIRTH CERTIFICATE / Continued

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY																																															
This information is not a part of the legal record of birth and will not be reproduced on certified copies																																															
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	8b. Date Last Normal Menses Began				8c. Month of Pregnancy				8d. Number of				8e. Birth Weight of this child																																		
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Previous Pregnancies - How many other pregnancies were-																																															
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8i. Aborted (less than 1 lb. or less than 20 wks.)						8j. Number of Living Children from other Pregnancies						8k. Date of Last Fetal Death																																			
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9a. Complications Related to Pregnancy				9b. Birth Injuries or diseases of Child				9c. Complications Not Related to Pregnancy																																							
<input type="checkbox"/> (2) None <input type="checkbox"/> (3) Preeclampsia <input type="checkbox"/> (4) Eclampsia <input type="checkbox"/> (5) Rh Sensitization <input type="checkbox"/> (6) Syphilis <input type="checkbox"/> (7) Rubella or other viral infection <input type="checkbox"/> (8) Anemia (hgb < 10gm/hct < 30%) <input type="checkbox"/> (9) Other				<input type="checkbox"/> (0) None <input type="checkbox"/> (1) Trauma - CNS <input type="checkbox"/> (2) Trauma - Other <input type="checkbox"/> (3) Difficult Resuscitation <input type="checkbox"/> (4) Hemolytic Disease <input type="checkbox"/> (5) Induced termination prior to viability <input type="checkbox"/> (6) Other				<input type="checkbox"/> (7) None <input type="checkbox"/> (8) Diabetes <input type="checkbox"/> (9) Heart Disease, Symptomatic <input type="checkbox"/> (0) Chronic Hypertension <input type="checkbox"/> (1) Chronic Renal <input type="checkbox"/> (2) Pyelocystitis <input type="checkbox"/> (3) Injury, tumor or surgery <input type="checkbox"/> (4) Other																																							
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decades led to the social as well as medical changes that effected a highly visible reduction in those rates.

The same degree of interest, if exhibited by physicians in supplying the data sought on the new certificate-of-live-birth form, will predictably lead to a comparable reduction in Georgia's morbidity rates. There is no one more qualified than the delivering

physician to assist in achieving this goal. With continued cooperation between the private and public segments of medicine, that symbolic first recorded birth of 1972 can signal the beginning of an era of scientific data collection and thoughtful analysis that will result in long-term benefits to thousands of other babies yet unborn.

SYMPOSIUM: PRESCRIBING EXERCISE FOR THE MAINTENANCE OF CARDIOVASCULAR HEALTH

DATES: Feb. 11, 12, 1972
Feb. 11 9:00 a.m.-5:30 p.m.
Feb. 12 9:00 a.m.-3:45 p.m.

FEE: \$50.00 Medical Doctors
\$15.00 Interns in Residence
PAYMENT OF FEES: May pre-register by paying fee in full
PLACE: University of North Carolina at Charlotte

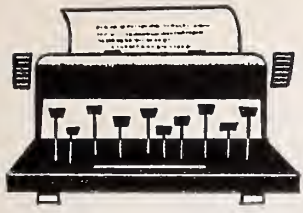
HOUSING: Downtowner Motor Inn (North-South Basketball these evenings at nearby Coliseum: N. C. State, Clemson, Georgia and University of North Carolina)

Name
Address
Street or Box No.
City State Zip Code

Return this form to:
Institute for Urban Studies & Community Service, UNCC
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Payment is enclosed () yes () no

Make checks payable to: Institute for Urban Studies & Community Service
A TIMELY PROGRAM FOR HEART MONTH



Governor's Re-Organization Plan

NEWS ITEM: "Five confrontations—one involving a drug crisis—convinced Gov. Jimmy Carter that the State Board of Health was no longer an essential part of state government. In fact, in his view, it was a hindrance."

Atlanta Constitution, Nov. 22, 1971

G GOVERNOR CARTER has publically vowed to abolish the State Board of Health and reduce the Health Department to bureau status by merging its functions with those of eight other departments and agencies into a bureaucratic hodge-podge to be known as the Department of Human Resources.

This new super agency would be composed of the existing Departments of Health, Corrections, Family and Children's Services (welfare), and Probation, plus the office of Economic Opportunity, Vocational Rehabilitation, Cooperative Area Manpower Planning, Pardon and Paroles, and the Commission on Aging.

Presiding over this department would be a politically appointed nine member board of directors, essentially lay in character. The Governor has assured one and all that physicians will be in a decided minority on the Board of Human Resources.

In addition to abolishing the Board of Health, the Governor's re-organization plan also provides for creating a separate division of mental health in direct opposition to the position held by the MAG Committee on Mental Health. This aspect of the plan, unfortunately, would tend to isolate mental health at a time when it desperately needs to be kept in the mainstream of medicine.

Compounding the urgency of this matter is the fact that the General Assembly must act negatively—that is, it must exercise a legislative veto—within 15 days after the 1972 session convenes on January 10. Failure to muster a majority vote in opposition to the plan means that the re-organization proposal becomes law.

The plan proposes many changes. In the field of health two seem to be of the greatest significance. First, the Board of Health, which has existed in some form since 1875, has been marked for extinction; and two, health policy, which for the most part has been set by health professionals for nearly a hundred years, would become the almost exclusive jurisdiction of politically appointed lay people who are neither trained or qualified to assume such responsibilities.

Ineptitude, however, may very well prove to be one of the lesser failings of such a Board. Of far greater and more serious potential is political involvement. No one has found a way yet to extricate from politics those boards forever accountable to a single elected official and anyone who thinks this Board would be different is just whistling past the graveyard.

Assuming that Governor Carter is motivated by the highest principles—and this editorial does not mean to imply anything differently—who can guarantee the motives of future Governors. Who can guarantee that great caution and expert judgment will be exercised in the making of appointments to this Board. Who can guarantee that marginal practitioners of dubious qualifications will not at some future date have great input to this Board. The answer to all these questions is

very simple; no one can. The only guarantee anyone has come up with yet is the present system or some semblance to it.

Bear in mind that this lay dominated Board will set and implement medical policy in Georgia. The extent to which the State engages in the practice of medicine, both institutionally and through local Health Officers, is but one example. There are others, but this seems to typify the pervasive nature of the Board.

MAG plans to oppose this re-organization proposal as vigorously as possible. To win, however, it must have help from the local level. MAG would like to urge that every member of the State Senate be contacted in person and convinced that our position is sound and the present system is worthy of being saved.

*Harrison L. Rogers, Jr., M.D., Chairman
MAG Committee on State Legislation*

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NONSENSE

*"A little nonsense now and then
Is relished by the wisest men."*
—Anonymous

I JUST DON'T KNOW who this fellow Anonymous really was, but he has come up with some prize morsels, and I believe the above quote is one of his better ones. Someone else once said that a doctor must have a goodly portion of faith, hope, and charity, and be endowed with a good sense of humor, with the latter perhaps being the most important. In the daily grind of treating people and sharing with them their heartaches, sufferings, and tragedies, it would be a dull and dreary existence if it were not for the occasional lighter side.

I well remember another quote that goes "Breathes there a man with soul so dead who never to himself (at least once) has said, 'I could write a book.'" Now, if I were going to write a book, and IF (and that's a big IF), I had just written down all the cute and humorous things that patients have said, or let slip, while in the course of conversation or during a physical examination, I'm sure they would fill a few volumes. I did save for posterity a few by writing them down, and some were so good that they just got fixed in my memory.

Since this is the month for giving and sharing and the time to be jolly, allow me to pass on to you a few of my pearls. Shortly after the holidays a couple of years ago I asked one of my younger patients what he had gotten for Christmas. He held up a pocket watch and said, "I got this here gold watch, and look, it's got my entrails engraved on the back."

When I asked one of my pre-schoolers just what it was he did in kindergarten, he replied, "Nothing but draw and go to the bathroom."

I well remember one patient's chief complaint was "Piles and Hemorrhoids." I told her, "I know you must really be in pain, for one is bad enough but to have both at the same time must be almost unbearable."

Many patients have had "diarrhea of the bowels" and others were afraid they would get "pneumonia of the lungs" and just the other day I was asked by a patient over the phone if I would send him something for a severe headache. "Doctor," he allowed, "my head is hurting so bad I'm sure I have a sinus in it." Another patient, when asked if he was bothered with indigestion, said, "Yes, Doctor, I have always had a gastric stomach."

Once while examining a child for headaches, I asked the mother if her daughter's eyes had ever been checked. Her reply was, "No, Doctor, they have always been blue."

An obese patient allowed as how everything she ate went to her stomach, and in getting the past history on another patient, regarding the patient's last treat-

PRESIDENT'S LETTER / Continued

ment by a doctor, the patient related that his last doctor had told him he had an inflated lung.

Recently, a patient stated, "I'm having trouble with my privacy." When asked to explain further he allowed that he had "a boil in my groin, right next to my urinal."

With that, I'd better quit, and hope that these few little true quips will enliven your holiday season. Many good wishes to you all, and I'll see you next month.

W. C. Mitchell

*W. C. Mitchell, M.D.
President, Medical Association of Ga.*

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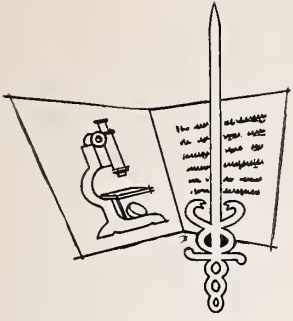
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THE MANAGEMENT OF LYMPHEDEMA

SAM A. THREEFOOT, M.D., *Augusta*

WHETHER LYMPHEDEMA IS PRIMARY, as in idiopathic lymphedema in a young person, or secondary, as in post-mastectomy lymphedema, the principles of management are similar. Surgical approaches have included attempts to (a) produce new lymphatic channels; (b) provide anatomic improvement or regeneration of existing lymphatic remnants; or (c) perform plastic reconstructive procedures. Medical and physiatriic methods have included (a) aid to function of existing lymphatics; and (b) stimulation of alternate pathways (other lymphatics, lymphaticovenous communications, or blood capillaries) for the return of protein and fluid normally transported by lymphatics. None of these has been completely satisfactory and investigations continue toward improvement.

The most important aspect of management by the family physician is the prevention of hard, brawny, irreversible edema. Prevention of irreversible edema depends upon maintenance of tissue fluid mobility by avoiding prolonged stasis and by the use of pressure (elastic sleeves or stockings properly applied) or pneumatic compression (with one of several devices on the market) to "milk" the fluid from the extremity. Elevation of the extremity and gravitational drainage may help in mobilizing fluid, especially in early and superficial pitting edema, without the use of special devices. Moderate exercise and isometric contractions while the extremity is elevated, although not an efficient method for consistent reduction of edema, may prevent further enlargement when no other means are available. As long as there is turnover of fluid and protein, the extremity will remain soft, sustaining hope for eventual relief from the edema. Hygienic care to avoid infection is of utmost importance. The lymphangitis which usually accompanies infection causes more edema, a good media for bacterial growth. Even if this cycle is broken by antibiotics the extremity is more fibrotic and larger after each episode. Diuretic therapy alone is ineffective for drastic reduction in the size of a lymphedematous extremity, but is a valuable adjunct in eliminating the fluid mobilized or redistributed by other procedures. Mercurial diuretics are usually more effective than thiazides. Severe dietary restriction of sodium is unnecessary but moderation is recommended.

Although lymphography is of great value in the diagnosis, classification, and detection of correctable obstruction it should not be performed in the presence of an inflammatory process or repeated without positive indication. Lymphography carries a risk of introducing or spreading infection, and the oil media may further embarrass uptake or transport by lymphatics and aggravate edema.

The specific details of management of lymphedema must be tailored to the individual patient. The regimen selected must be carried out regularly, frequently, and extended over a long time. While reaccumulation of edema may be expected, there are some reports of a high percentage of success with intensive use of pneumatic compression and elastic supports. Careful attention should be given those psychological factors directed toward relieving anxiety, especially when the

patient is advised of the possibility of long term treatment and of the cyclic variation in the state of edema. He must understand the therapeutic objectives and the importance of preventing fixation of protein and enlargement of the extremity in order to cooperate fully and not discontinue treatment in a discouraged moment if no reduction in the size of the extremity is achieved.

In summary, the principles of management of lymphedema include maintenance of mobility of interstitial fluid and protein, prevention of wounds and infections, and attention to the patient's morale.

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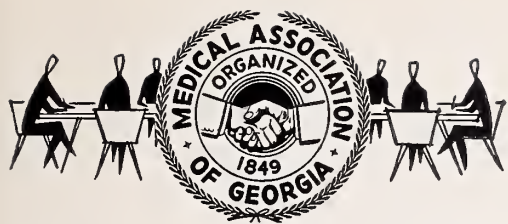
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PERSONALS

Second District

James A. Hubbard of Albany has been elected to Fellowship in the American College of Obstetricians and Gynecologists.

Fourth District

Albert P. Rauber of Decatur has been named professor of pediatrics at Emory University School of Medicine.

Fifth District

Samuel S. Ambrose of Atlanta has been named professor of surgery (urology) at Emory University School of Medicine, effective January 1.

Dorothy E. Brinsfield has been promoted to professor of pediatrics at Emory University School of Medicine.

Edgar Boling of Atlanta was named president-elect of the Southern Medical Association at the group's 65th annual meeting in Miami Beach in November.

J. Willis Hurst of Atlanta was installed as president of the American Heart Association at that organization's annual meeting in Anaheim, California, in November.

Tenth District

Cheney C. Sigman, Jr., of Atlanta, opened an office on a part-time basis in Madison in November. He will initially treat patients in the field of Allergy of Adults and Children, later including patients in Pediatrics and Adolescent Medicine.

DEATHS

Arthur M. Knight, Jr.

Arthur M. Knight, Jr., died October 18 in Waycross at the age of 57.

A native of Waycross, he received his B.A. degree in economics from Emory University and his M.D. degree from the University of Georgia College of Medicine, from which he was graduated with top honors. He served his internship at the U.S. Naval Hospital in Jacksonville and St. Vincent's Hospital in Jacksonville. He served a residency in internal medicine at Johns Hopkins Hospital in Baltimore, and began practice in Waycross in 1947.

Dr. Knight was chief of the Waycross Heart Clinic, served as president and on the board of directors of the Georgia Heart Association and as chairman of the association's clinics committee. He was widely known as a lecturer on cardiology and internal medicine.

Dr. Knight was a member and former president of the Ware County Medical Society, member of the Medical Association of Georgia, American Medical Association,

the Johns Hopkins Medical and Surgical Association and was a fellow of the American College of Cardiology.

He is survived by his widow, the former Nina Belle Hopkins, Waycross; two daughters, Mrs. Richard (Suzanne) Hostetter, Lookout Mountain, Tenn., and Mrs. William Berry (Connie) Dial, North Augusta, S.C.; one son, Arthur M. Knight, III, Waycross; a sister, Mrs. Virginia Conoly, Valdosta; a brother, Henry S. Knight, Columbia, S.C.; and four grandchildren.

Vernon E. Powell

Vernon E. Powell, 71, died October 4 in New Smyrna Beach, Fla.

Founder of the Georgia chapter of the Arthritis and Rheumatism Foundation and assistant clinical professor at Emory University Medical School since 1948, he was born in Atlanta and was graduated from Emory University at Oxford. He received his M.D. degree from Emory in 1923.

Dr. Powell was on the staff at Emory, Grady and Piedmont hospitals and St. Joseph's Infirmary. He was president of Emory Hospital staff in 1947.

He was a veteran of World War I and World War II and a member of the Fulton County Medical Society, the Medical Association of Georgia, the Southern Medical Association, the American Medical Association, the American College of Physicians, the American Clinical Society and the American Heart Association.

Dr. Powell was also a member of Kappa Alpha fraternity, Phi Chi medical fraternity, the Masons, Peachtree Road Methodist Church, the American Legion, Piedmont Driving Club and the Capital City Club.

He is survived by his widow, a daughter, a son and two sisters.

Frank H. Thomas

Frank H. Thomas died October 18 in a Valdosta nursing home at the age of 95.

He began practice in Valdosta in 1906, retiring in 1967 at the age of 91.

A member of First Christian Church, he is survived by a daughter, Mrs. Virginia T. Parramore of Valdosta; a sister, Mrs. W. F. Pendleton of Valdosta; a grandchild and a great-grandchild.

Ernest F. Wahl

Ernest F. Wahl died October 8 at Tallahassee Memorial Hospital. He was 75.

Receiving his M.D. degree from the University of Iowa, he spent his residency at Cincinnati General Hospital and Johns Hopkins University.

Dr. Wahl did postgraduate work at Massachusetts General Hospital, where he studied cardiology under Dr. Paul Dudley White. He began practice in Thomasville in 1926 as a resident diagnostician.

A former chief of staff at Archbold Memorial Hospital, Dr. Wahl was a member of the American Medical Association, the American College of Physicians, the American College of Chest Physicians and the Medical Association of Georgia. He was a charter member and past president of the Georgia Heart Association.

He is survived by his widow, the former Marjorie Martin of Central City, Nebraska; a daughter, Mrs. R. D. (Ann) Stipe, Orlando, Florida; a son, Ernest F. Wahl, Jr., Thomasville; and a sister, Mrs. Morton Endee, Westchester, Iowa.

THE MONTH IN WASHINGTON

The long awaited public hearings on the various proposals for national health insurance before the House Ways and Means Committee are now underway. Some 200 organizations and individuals are expected to testify during the scheduled six weeks of hearings.

Lead off witness was HEW Secretary Elliot Richardson who revealed an entirely new proposal "to tighten controls on provider costs and inefficiencies."

The Secretary also outlined the long-awaited program for regulating private health insurance companies. In the 38-page statement, Richardson was highly critical of the Kennedy-Labor Bill.

Richardson said the provider controls and the insurance company plan will be submitted in legislative detail to the Committee shortly.

Text Summary

Following is a summary of the Administration's text on the provider plan:

"In order to help the consumer become a prudent buyer in the medical care market and to protect the consumer against unnecessary increases in health care costs, we shall propose the following provisions:

". . . The states shall require health insurance companies to inform prospective policyholders as to benefits, exclusions, premium costs and delivery system choices.

". . . The states shall require providers to inform the public as to charges for standard items and other patient access matters.

". . . We will establish on an experimental basis local quality review organizations composed of outside medical experts, including non-providers in some instances.

". . . We also propose to require NHISA carriers to apply control measures and statistical reporting measures in accordance with Federal guidelines, such as strict review of utilization of health care services. Specific plans for implementation with regard to wages and prices will be developed in conjunction with the Committee on the Health Industry established by the President under Phase II of his new economic policy.

". . . State planning agencies will be required in cooperation with area-wide planning agencies and as a condition of Federal grant support and approval, to identify geographic areas of physician and facility oversupply. States are to develop and apply detailed criteria based on Federal guidelines, and publish this information."

Insurance Regulations

Under the proposed insurance company regulations, Richardson said:

"We intend to secure agreements with states under which the states will

". . . Require annual, independent audits of participating insurance companies.

". . . Create state health insurance insolvency mechanisms. A Federal mechanism will also be established for use if a state fails to act satisfactorily.

". . . 'File and use' procedures for premium rates under NHISA insurance contracts, with authority to disapprove extraordinary rates.

". . . Require disclosure by insurers of their administrative expenses as a percentage of premiums.

". . . Create state insurance pools, on a state-wide or sub-state basis open to small employers, the self-employed, and those who are not employed, but are ineligible for Federally-financed health programs."

Richardson Predictions

Richardson said he was certain the hearings "will culminate in a national health insurance program." The Administration's plan avoids the danger of two extremes—proposals that do little to alter the present system and proposals to substitute a monolithic Federal scheme, he declared. Richardson said proponents of the Kennedy-Labor Bill "seem to assume that radical intervention by the Federal Government in health care, in an inflexible, predetermined and monolithic manner, is the only way to solve health organization and delivery problems. I suggest that we are more likely to attain our common health objectives by stimulating competition and by promoting consumer education and freedom of individual choice, rather than by resorting to fiscal coercion and unrealistically global schemes." He estimated it will cost \$60 billion in new taxes.

The American Medical Association's Mediredit and the Health Insurance Association of America's plan also were criticized. The major shortcoming in both, said Richardson, "is the great unlikelihood of achieving universality in protection."

The catastrophic protection plans, standing alone, "do very little for very few people—far less than what this nation must do if it is to act with a full sense of responsibility," the HEW Secretary testified.

Provider Problems

Mills opened the hearings by noting that health providers are beset by many problems. High quality care is available but unevenly distributed, he said, and costs are rising; there is lack of planning; the nation depends on importing foreign graduates; and consumers often find care difficult to get.

With the Administration's testimony in hand, the Committee then turned to the long parade of witnesses from such diverse organizations as the College Democratic Clubs of America to the Senior Citizens Golden Ring Council to ascertain how they think the nation's health care system should be reshaped.

Labor Position

AFL-CIO President Meany told Committee members that "Labor will vigorously oppose" any efforts to dilute its plan for national health insurance.

"I hope and firmly believe that we won't have to come back in the next Congress," Meany said. "But, if we have to, we will come back again and again until the Health Security Program is enacted. And, if we have to, we will take this issue to the people in the elections of 1972."

Meany blasted the national health insurance proposals of the Administration, the health insurance industry, and the AMA—saying they "would all just

WASHINGTON / Continued

pour new money into the present health care delivery system which is a failure."

He said that AMA's Medcredit "represents a major shift in direction for organized medicine . . . but it is little more than a continuation of the present unsatisfactory system of delivering health care."

Meany scoffed at warnings that physicians might rebel if the labor bill is enacted. "The vast majority of doctors are dedicated, proud professionals whose basic concern is for the sick and ailing."

Fiscal Considerations

Committee member Hugh L. Carey (D., N.Y.), told the labor witnesses when the committee meets in executive session it must face the fiscal considerations involved and try to develop a measure that fits within some dollar figure. He asked whether labor would be willing to make a choice between comprehensive coverage for part of the population or basic coverage for all. A labor witness replied to the effect labor does not want to make such a choice now. "We will cross that bridge when we get to it."

The American Farm Bureau Federation urged caution against the creation of "a powerful bureaucracy of great scope" and the National Federation of Independent Business came out flatly against any compulsory insurance system.

The American Public Health Association called for a broad national program with heavy emphasis on speeding development of pre-paid group plans. The goals set forth by James Kimmey, APHA Executive Director, fit the labor bill more than any other proposal, but the association did not endorse a single measure.

Insurance Viewpoint

Equitable Life Assurance Society President, J. Henry Smith, accompanied by Daniel Pettengill and Ardell T. Everett, presented the combined statement of the Health Insurance Association of America, American Life Convention, Life Insurance Association of America, and Life Insurers Conference.

Smith urged enactment of "The National Health Care Act of 1971" the insurance companies' plan under which federal standards would be set for insurance coverage, personal and corporate income tax incentives would encourage participation, and federal-state subsidies would finance coverage for the indigent and medically indigent as well as uninsurable persons with sliding scale contributions for premiums.

Comprehensive health insurance should be available to all, Smith said. "This can best be achieved at lowest cost and most rapidly by expanding the scope of existing health insurance plans . . . for those without resources, governmental subsidies are required."

"The choice between a pluralistic private insuring mechanism and a monolithic federal one is a fundamental choice that must be made before any national health insurance plan can be adopted. We think our record of accomplishments is good and our potential is great."

Rising Costs

Replying to charges private companies have failed to stem rising costs, Smith said the principal causes

have been rising wages, more costly equipment and expensive new life-saving techniques. He asked whether insurers were supposed to prevent these developments.

Furthermore, the witness said, "insurers have tried hard to spot and control overcharging. We have worked with medical societies to set up peer review committees, not just for the purpose of catching overcharges but for the purpose of educating physicians not to overcharge in the first place."

The National Association of Insurance Commissioners urged preservation and expansion of the existing system of private health insurance and recommended utilization of the state insurance regulatory mechanism rather than a new federal one.

"The abandonment of the extensive system of private health insurance in favor of an all government program would reject decades of expanding and improving an on-going system and would cause severe dislocation in both state and federal revenues," said Russell van Hooser, Insurance Commissioner of Michigan.

The International Association of Health Underwriters "wholeheartedly" supported the Private Insurance Company Bill.

Comments

The American Dental Association said any National Health Program should start out with a dental component that concentrates on preventive services for children. Any program approved should include dental benefits. The same stand was taken by the American Society of Oral Surgeons.

Leonard Woodcock, President of the United Auto Workers Union, told the Committee "it is time to cancel the insurance industry" and impose a national health insurance program operated by the government.

Woodcock opposed the Administration's proposal to require employers to provide employees with health insurance from private firms, saying organized labor helped to create the private health insurance industry, and supported it for three decades.

Insurance Failure

"But the private health insurance industry has failed," Woodcock said. "It has failed to control costs. It has failed to provide adequate benefits even for those with some form of coverage. After 30 years of effort, all private health insurance combined still covers only a little more than one-third of private personal health care expenses."

Woodcock said the Nixon plan would not regulate the insurance industry although it would require purchase of \$30 billion of private insurance.

"It is time to cancel an insurance industry that places a premium on sickness rather than health and that puts the interests of consumers last in line," Woodcock said.

Pharmacists represented by the American Pharmaceutical Association urged the Committee to include drugs in any health insurance plan. The Committee is not expected to act on health insurance legislation until next year.

William G. Battaile, President of the American Association of Blood Banks, asked that no coverage be

provided to pay for blood transfusions. He contended that payments would encourage greater use of commercial blood banks and increase the risk of hepatitis.

At the end of the second week Ways and Means Chairman Wilbur Mills had attended only one of the hearings and other committee members seemed to be platonizing themselves in the arduous task of listening to the opinions of so many diverse organizations and individuals.

Health Finances

Expected to be signed into law shortly is health manpower legislation that will authorize an estimated \$2.9 billion in aid to health profession students and their schools in the next three years—and provide the facilities and programs to close the manpower shortages in the health professions within seven years.

Medical schools would receive \$11,500 for the full-term cost of training each student. Each school would receive \$2,500 per student per year for the first three years of training. The grant rises to \$4,000 for the year of graduation. In order to encourage swifter training, three year schools would receive \$13,500 based on \$2,500 for each of the first two years and \$8,500 for the third year.

Each school would be required to enroll an additional five per cent of students, or five students . . . whichever is the greater . . . to qualify for assistance. An extra \$1,000 a year would be awarded schools for each student exceeding this total. The legislation will also help establish at least five new medical colleges.

Additional authorizations would provide \$270 million for health manpower education initiative awards to alleviate manpower shortages and to train new types of personnel, and \$412 million for special project grants for programs in family medicine, physician assistant training, and others. The bill continues support for scholarship and student loans at increased levels as has been provided heretofore in the Health Professions Educational Assistance Act.

Cancer Opposition

House opposition to a Senate-passed cancer bill that would tend to fragment the National Institutes of Health has touched off a debate in Washington as to how best to organize a multimillion dollar campaign to conquer the disease. The American Cancer Society has sponsored a number of full-page ads about the nation calling for popular support of the “put-a-man-on-the-moon” approach to the conquest of cancer as contained in the Senate bill.

Florida’s Congressman Paul Rogers, chairman of the House Interstate and Foreign Commerce Subcommittee on health, and himself the author of a “cancer attack” bill that would beef-up cancer research but keep it within the framework of NIH, immediately branded the Cancer Society ads as “an attempt to bring the issue of finding a cure for cancer into a political setting.”

It is reported here that the Cancer Society ads are just the opening salvo in a “big money” grass roots campaign to pressure the Congress into passage of the Kennedy-Administration backed “Conquest of Cancer” bill. A month ago the AMA’s testimony on this bill challenged the wisdom of separating cancer research

from the mainstream of biomedical research now carried on by the NIH.

Cost Control Committee

President Nixon formally established a committee on the health services industry to furnish advice on ways to keep health costs from climbing too rapidly. In an executive order, the chief executive said the committee—which is expected to consist of about 15 members—“shall provide advice concerning special considerations that tend to contribute to inflation in the health services industry.”

Members of the advisory panel, due to be named shortly, shall be generally representative of medical professions and related occupations, hospitals, the insurance industry, other supporting industries, consumer interests and the public, according to the presidential order.


Health care was singled out by the Administration for special consideration in the Phase Two Program of wage-price controls that will be administered by a cost of living council to which the health advisory group will report.

The extent to which the program will affect the medical profession and details of how it will work and what guidelines and/or controls may be promulgated have not been disclosed. However, a White House background paper spoke of “voluntary cooperation.”

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AN ACCOUNT OF THE FOXGLOVE

An old woman of Shopshire, England, where Dr. William Withering (1741-1799) was born, developed a local reputation for a brew of herbs that was useful in relieving patients with dropsy. After much persuasion Dr. Withering obtained a handful of her herbs. He then spent several months in studying the effects of the 20 herbs that were included in her formula, and finally concluded that only one of them was really of value. That was the purple foxglove from which is derived the drug we now know as digitalis.

Country folk in those days in Yorkshire, England where Dr. Withering was practicing, drank quantities of foxglove "tea" whenever they became dropsical. He was called to treat a man suffering from incessant vomiting, his vision was blurred, and his heart was beating at an alarmingly slow rate, 40 beats per minute. These are now well known symptoms of over-dosage of digitalis.

The man's wife had brewed a handful of green foxglove leaves in a pint of water which the patient finished in one draft. The "tea" had relieved the man of his symptoms of dropsy, but had brought on other unpleasant symptoms.

Through 10 years (1775-1785) of painstaking study, Dr. Withering kept a careful record of all patients who were treated by him with foxglove tea (infusion of digitalis). His book "An Account of the Introduction of Foxglove in Modern Medicine" was published in 1785. In this book he explained what digitalis does in heart disease. Present day physicians can scarcely improve on his observations.

Dr. Withering knew not only what the drug could do but most important he knew when to stop giving it. If given for too great a period of time digitalis, when uncontrolled, could result in death.

With modern laboratory methods, several potent cardiac glycosides have been isolated from foxglove. These include digoxin, digitoxin, gitoxin, gitalin, and others.

Through his careful studies Dr. William Withering showed physicians the proper use of digitalis, a powerful drug of great value in certain forms of heart disease.

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to move,
and the Latin *sedatus*,
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its throat membrane with air until it is
twice the size of its head.

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